DELAWARE STATE MEDICAL JOURNAL

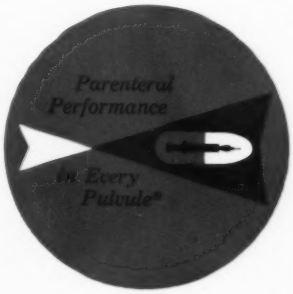
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bibliography: (1) Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 136. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* **4**:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* **55**:2338, 1955. (6) Lemere, F.: *Northwest Med.* **53**:482, 1954. (7) Perlstein, M. A.: *Pediat. Clin. North America*: **4**:1079 (Nov.) 1957. (8) Livingston, S., & Pauli, L.: *Pediatrics* **19**:614, 1957. (9) Carter, C. H., & Maley, M. C.: *Neurology* **7**:483, 1957. (10) Keith, H. M., & Rushton, J. G.: *Proc. Staff Meet. Mayo Clin.* **33**:105, 1958.


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Official Publication of the Medical Society of Delaware

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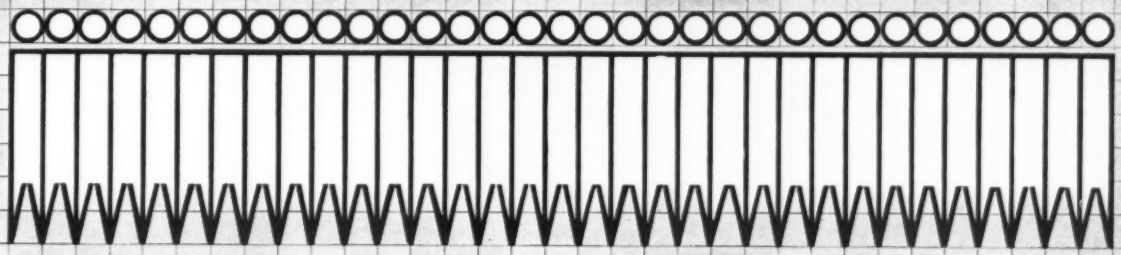
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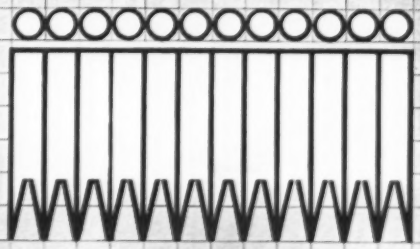
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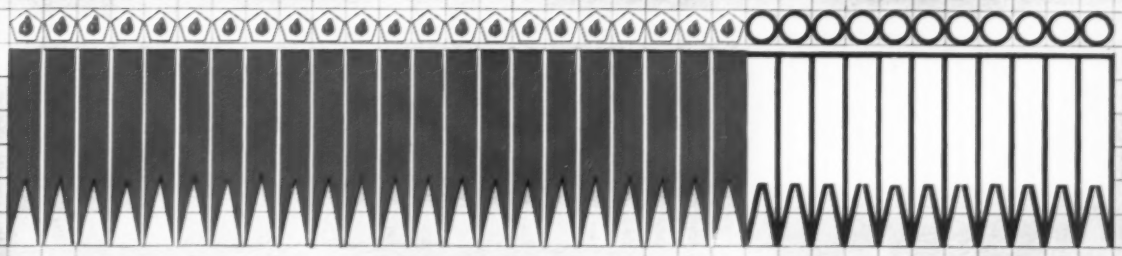
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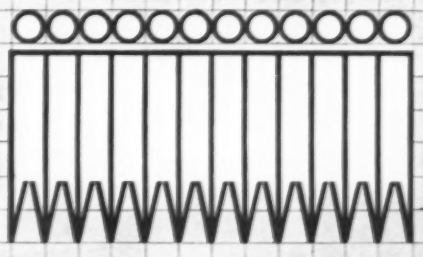
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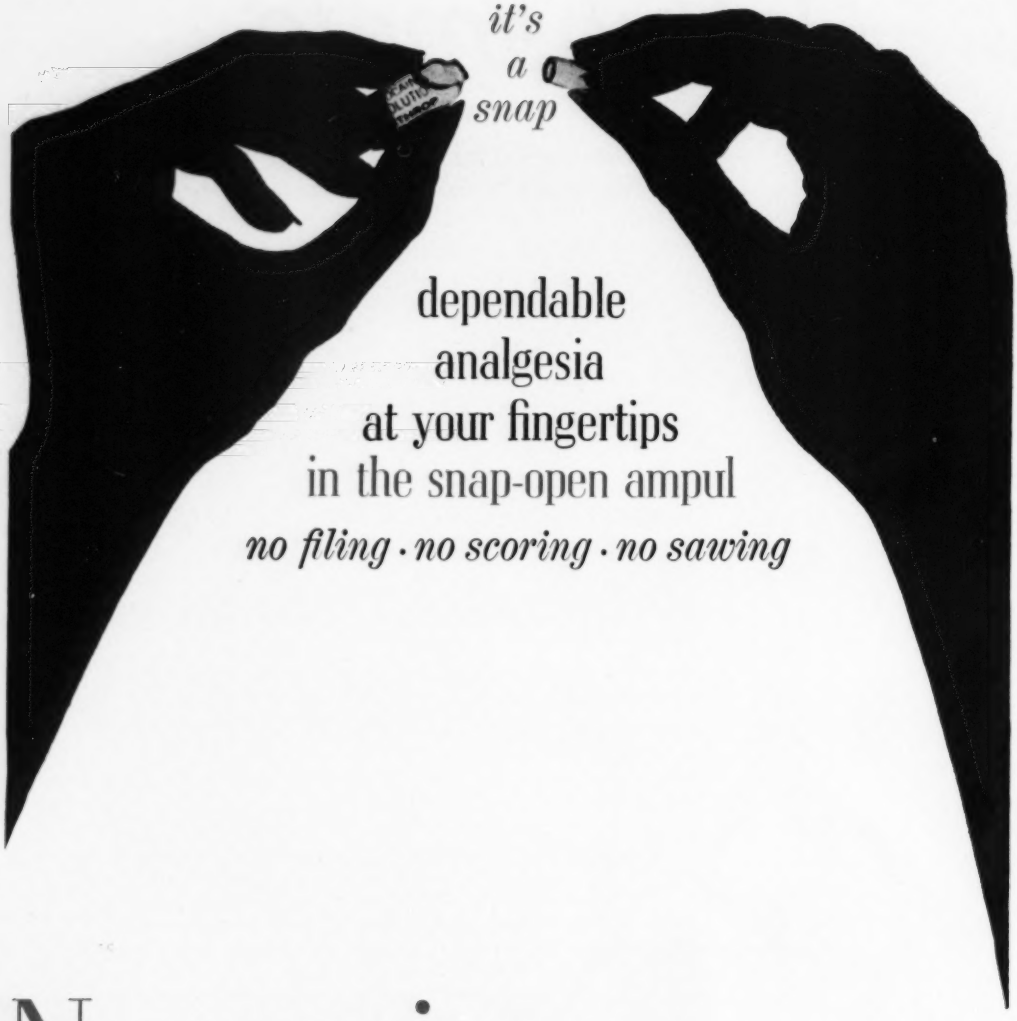
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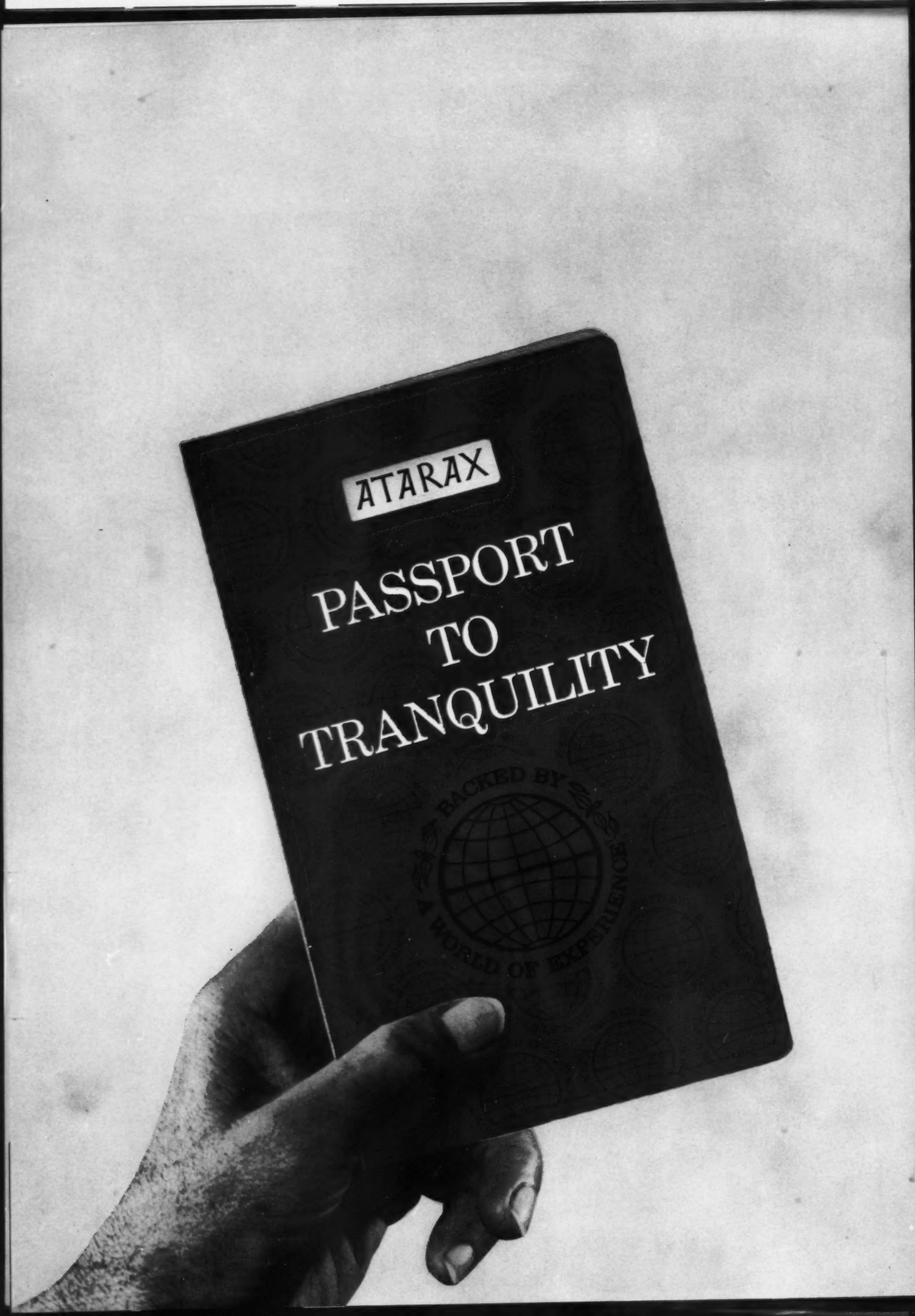
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References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pflegger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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Sun., Oct. 11, 1959, The Dinkler-Tutwiler Hotel

TACOMA, WASHINGTON
Wed., Oct. 14, 1959, The Hotel Winthrop

TRAVERSE CITY, MICHIGAN
Fri., Oct. 23, 1959, The Park Place Hotel

LUBBOCK, TEXAS
Sat., Oct. 31, 1959, The Lubbock Country Club

ST. CHARLES, ILLINOIS
Wed., Nov. 4, 1959, The St. Charles Country Club

DALLAS, TEXAS
Fri., Nov. 6, 1959, The Hilton Hotel

WICHITA, KANSAS
Sat., Nov. 7, 1959, The Hotel Broadview

SCHENECTADY, NEW YORK
Thurs., Nov. 12, 1959, The Mohawk Golf Club

CORPUS CHRISTI, TEXAS
Fri., Nov. 13, 1959, The Robert Driscoll Hotel

RIVERSIDE, CALIFORNIA
Sun., Nov. 15, 1959, The Mission Inn

SANTA BARBARA, CALIFORNIA
Wed., Nov. 18, 1959, The Santa Barbara Biltmore

MOLINE, ILLINOIS
Wed., Dec. 2, 1959, The LeClaire Hotel

1960 Symposia (incomplete schedule)

DENVER, COLORADO
Sun., Jan. 10, 1960, The Cosmopolitan Hotel

AUSTIN, TEXAS
Fri., Jan. 15, 1960, The Commodore Perry

POCATELLO, IDAHO
Sat., April 2, 1960, The Bannock Hotel

MOORHEAD, MINNESOTA
Sat., April 9, 1960, The Frederick Martin Hotel

SALT LAKE CITY, UTAH
Fri., April 22, 1960, Hotel Utah

ST. LOUIS, MISSOURI
Sun., May 1, 1960, Chase-Park Plaza

SANTA ROSA, CALIFORNIA
Fri., Sept. 16, 1960, The Flamingo Hotel

GREAT FALLS, MONTANA
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2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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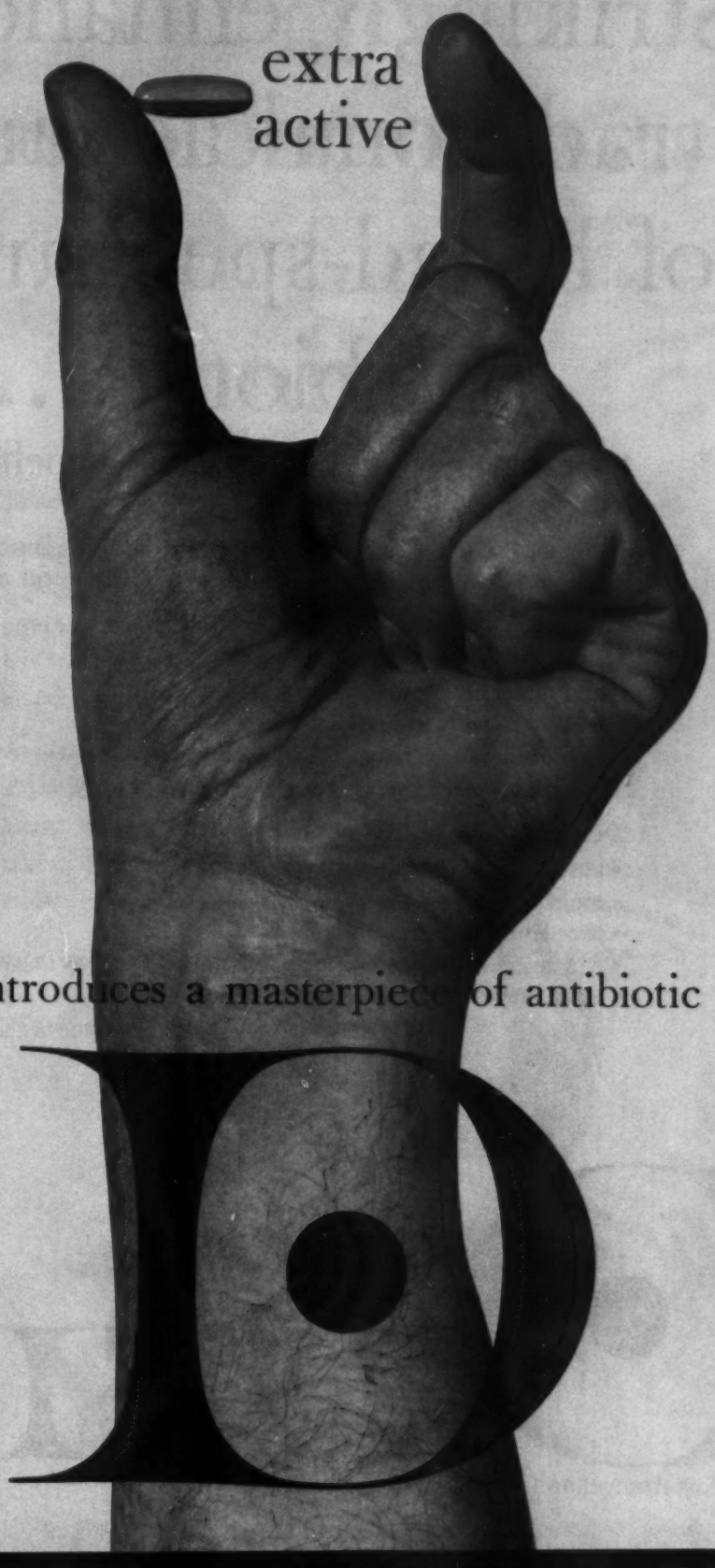
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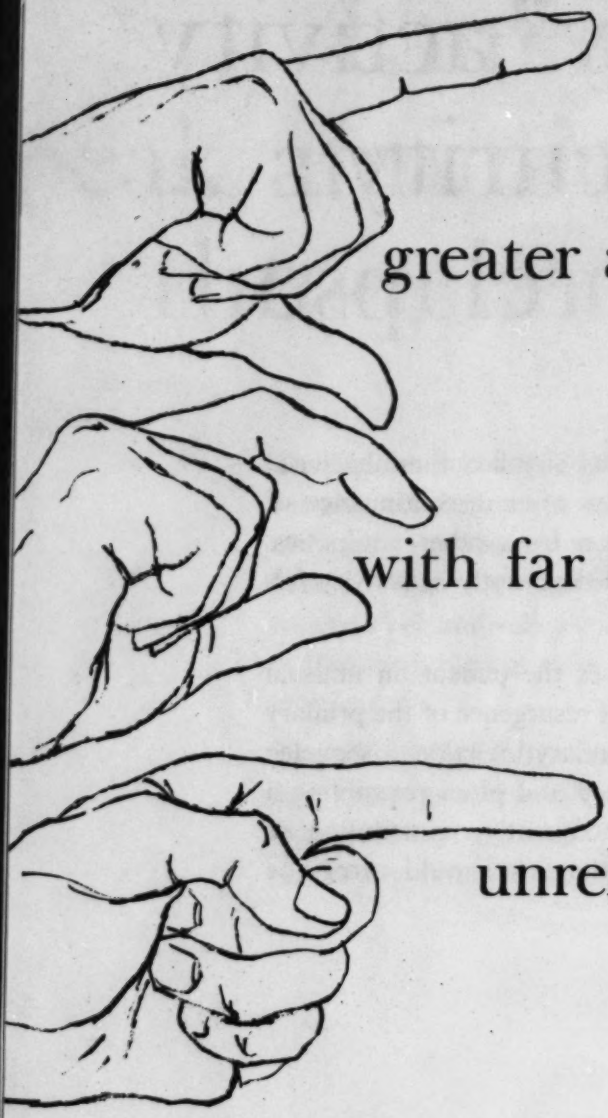
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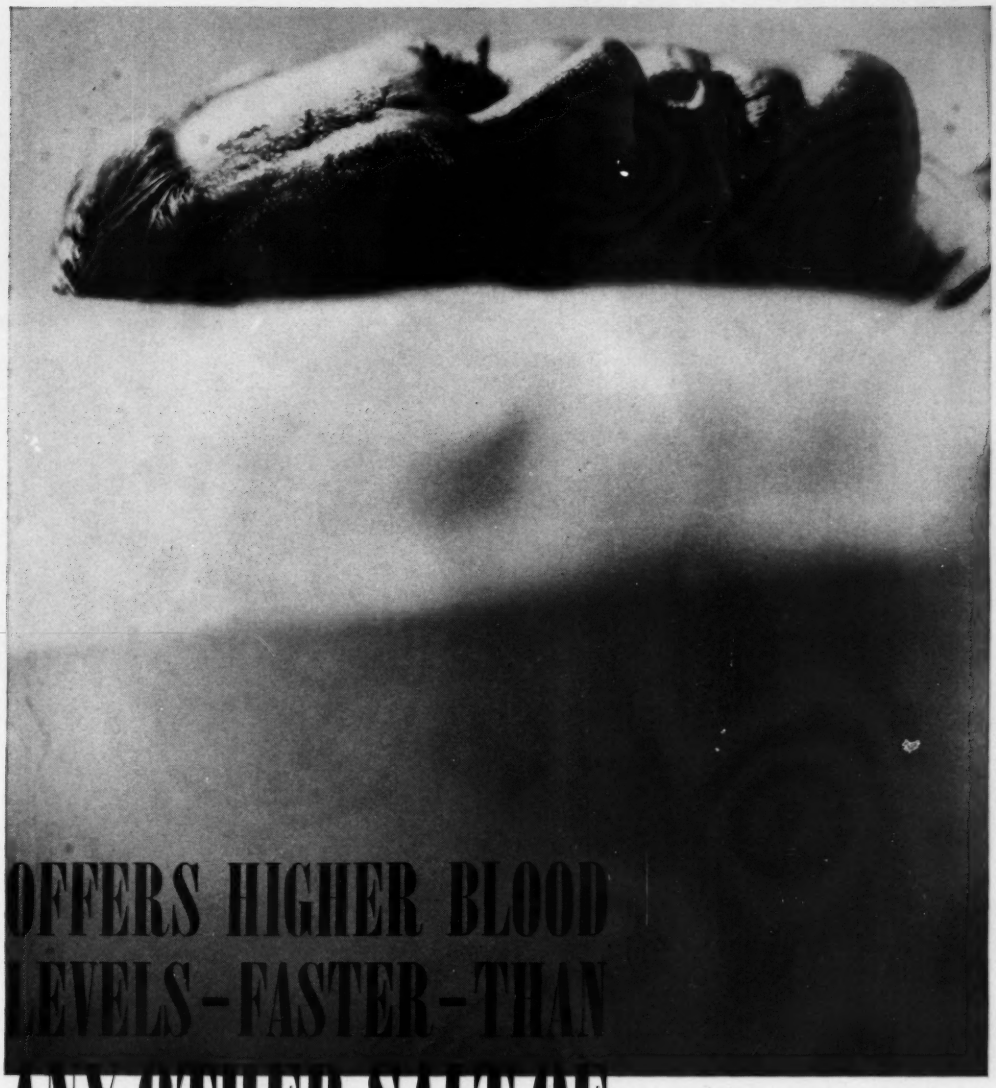
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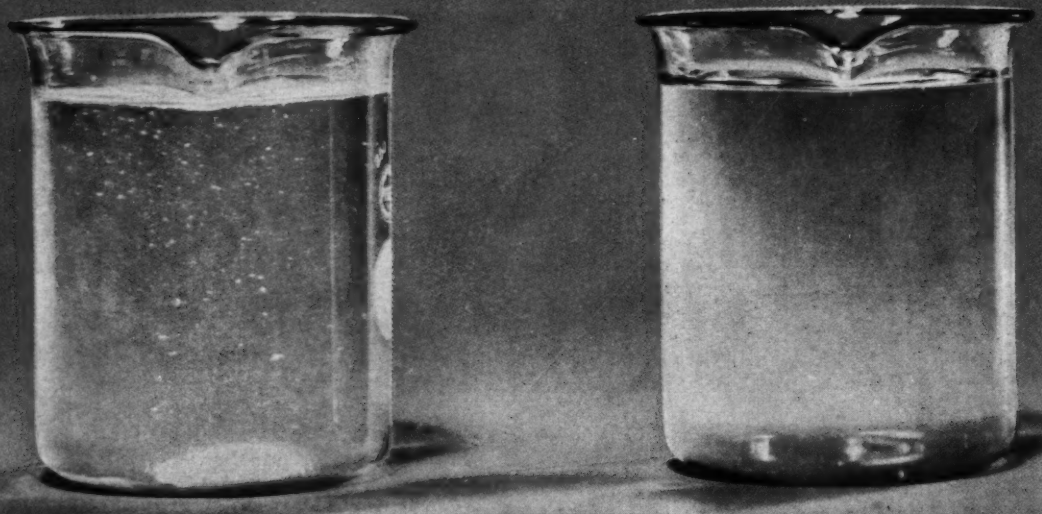
® FILMTAB — FILM-SEALED TABLETS, ABBOTT, U.S. PAT. NO. 2981095

in tiny, easy-to-swallow Filmtabs® in tasty, cherry-flavored Oral Solution

avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[1,3] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2,4,5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage

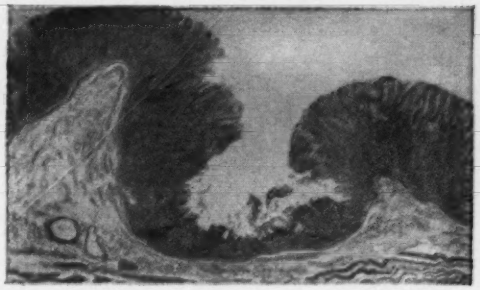


Regular aspirin crystals 24 hours after being mixed into water.

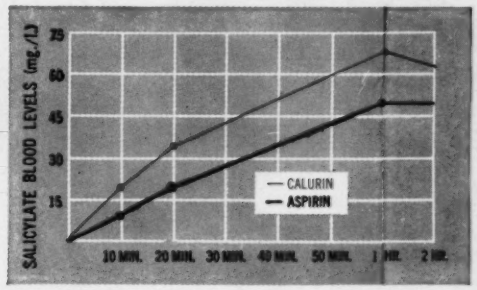
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, Lancet 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. 258:219, 1958. 10. Editorial: Aspirin plain and buffered, Brit. M. J. 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

*TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska



NIAMID*

the mood brightener

EFFECTIVE AND WELL TOLERATED

in depression

NIAMID has been found to be strikingly effective and well tolerated in a broad range of depressive states including a wide variety of the milder depressive syndromes, as well as the masked depression so frequently seen in general practice. These syndromes include: depression associated with the menopause, postoperative depressive states and senile depression; depression accompanying chronic or incurable illness, such as gastrointestinal and cardiovascular disorders and inoperable cancer.

in angina pectoris

NIAMID, in intensive clinical tests, has proved to have a high degree of safety and to be a valuable adjunct in the management of the anginal syndrome. NIAMID produces striking symptomatic improvement in angina patients — markedly reduces the pain, severity and frequency of anginal episodes, reduces nitroglycerin requirements, and provides an increased sense of well-being. Since dramatic improvement is seen in some patients, it is wise to advise the patient against overexertion — his disorder still holds potential dangers despite relief of symptoms.

DOSAGE: Start with 75 mg. daily in single or divided doses. After a week or more, adjust the dosage, depending upon patient response, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to the maintenance level. Many patients respond to NIAMID within a few days, others in 7 to 14 days. A few patients may require as much as 200 mg. daily over a longer period of time before significant improvement is seen.

PRECAUTIONS: Side effects are infrequent and mild, and often lessened or eliminated by a reduction in dosage. Hypotensive effects have rarely been noted and no jaundice or other evidence of liver damage has been reported in patients receiving NIAMID. However, in patients with a history of liver disease, the possibility of hepatic reactions should be kept in mind.

SUPPLY: NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already clinically proved in several thousand patients—

Complete references and a Professional Information Booklet giving detailed information on NIAMID are available on request.

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*Trademark for brand of nialamide

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whenever there is inflammation, swelling, pain

VARIDASE®
STREPTOKINASE-STREPTODORNASE LEDERLE
BUCCAL *Tablets*

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MONDAY: size down to small tab; acute inflammation disappeared.*

VARIDASE activates natural fibrinolytic factors, to limit undesirable inflammatory response and speed healing.

Dramatic reduction of pain is often the first sign of improvement; swelling and redness rapidly diminish. Drugs and natural regenerative factors readily penetrate the inflammatory barrier to effect total remission faster... in trauma or infection.

VARIDASE Buccal Tablets contain:
10,000 Units Streptokinase, 2,500 Units Streptodornase.
Supplied: Boxes of 24 and 100 tablets

*Peterman, R. A.: Clinical report cited with permission.

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Synonyms for Pain Relief...

'TABLOID'
'EMPIRIN' COMPOUND®

Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½

'TABLOID'
'EMPIRIN' COMPOUND® WITH CODEINE PHOSPHATE*

No. 1
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ⅛

No. 2
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ¼

No. 3
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ½

No. 4
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. 1

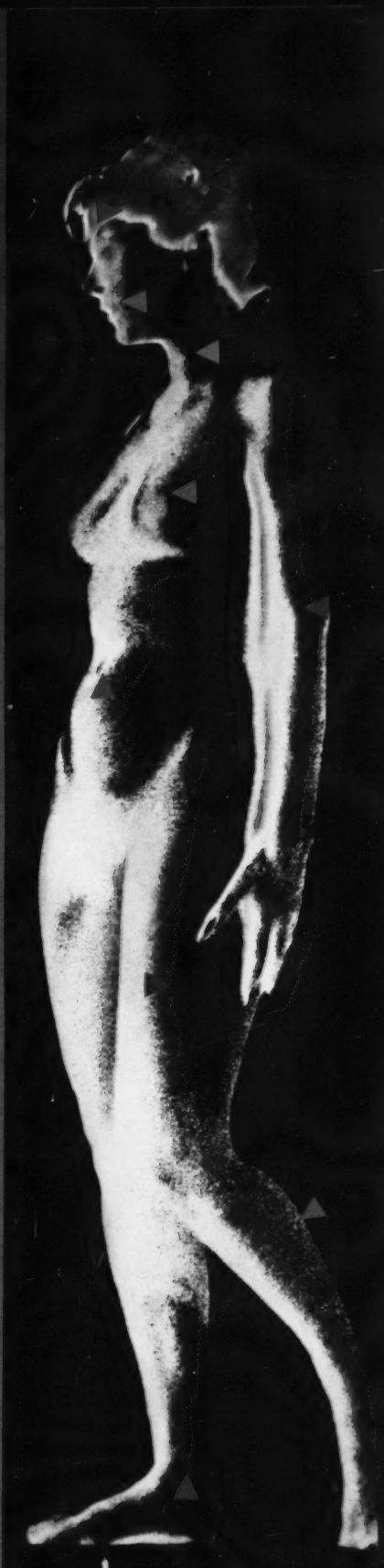
*Subject to Federal Narcotic Regulations

...providing the desired gradation of potencies for relief of varying intensities of pain

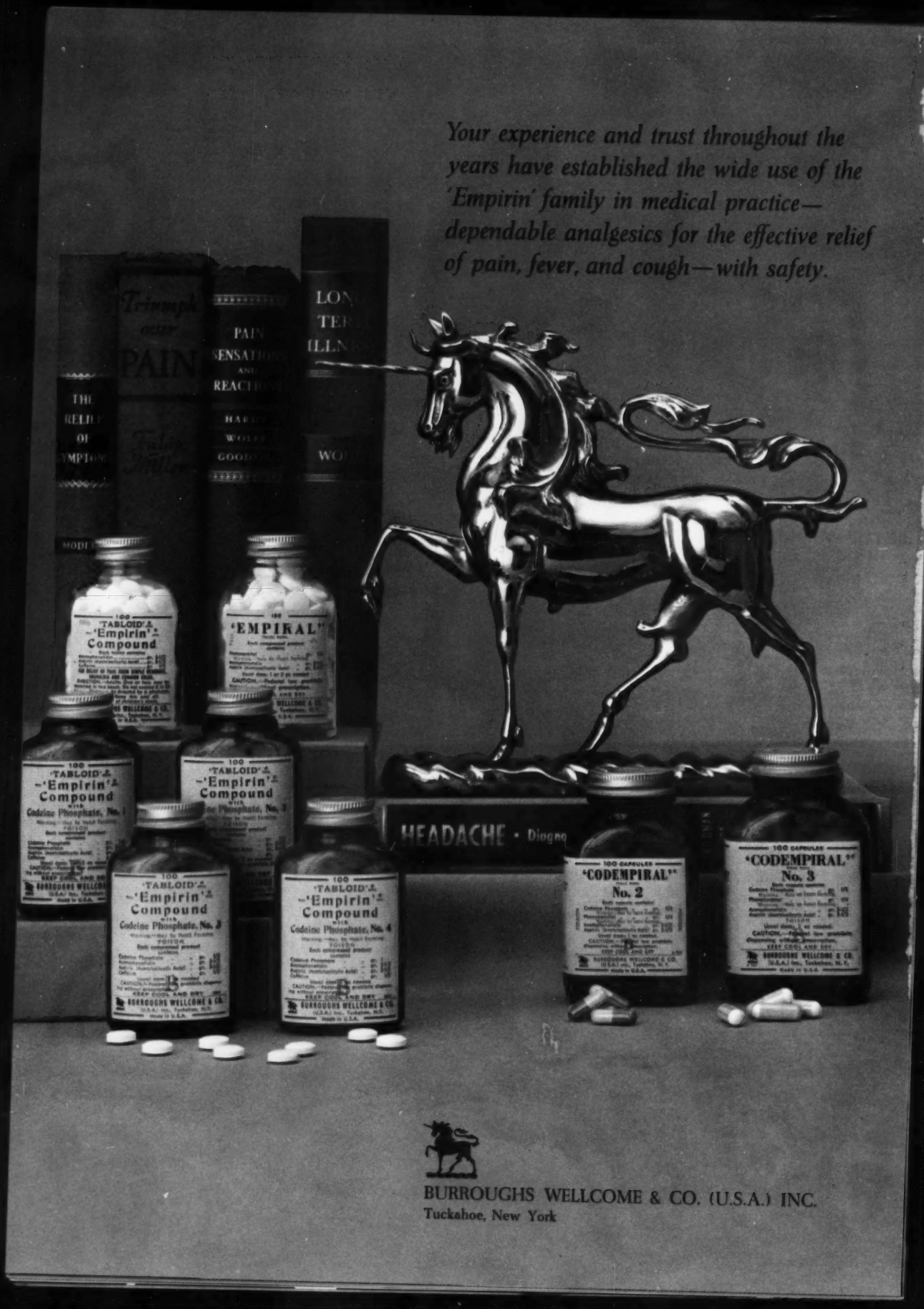
IN
simple headache
rheumatic conditions
arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
minor trauma
tension headache
premenstrual tension
minor surgery
post-partum pain
trauma
organic disease
neoplasm
muscle spasm
colic
migraine
musculo-skeletal pains
postdental surgery
post-partum involution
fractures
synovitis/bursitis

relief of pain of all degrees of severity up to that which requires morphine

AND IN
fevers
dry, unproductive coughs



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Clear the air

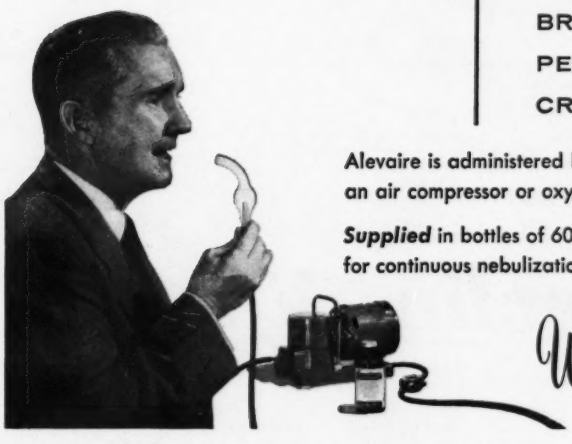
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CROUP

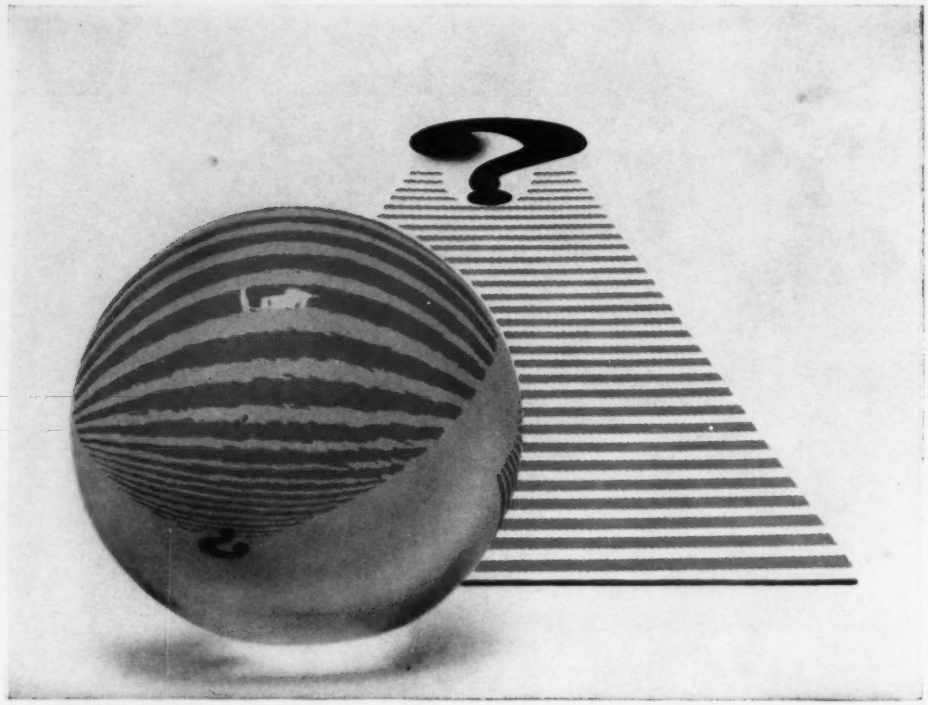


Alevaire is administered by means of a nebulizer operated with an air compressor or oxygen.

Supplied in bottles of 60 cc. for intermittent and 500 cc. for continuous nebulization.

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what lurks beyond the broad spectrum?

"Broad spectrum" has evolved into an especially apt term to describe a growing number of "specialized" antibiotics. These provide the best means of destroying pathogenic bacteria which range all the way from large protozoa through gram-negative and gram-positive bacteria to certain viruses at the far end of the spectrum.

But beyond the spectrum lurk pathogenic fungi. Aggressive infections often require intensive broad spectrum antibiotic attack. It becomes more apparent every day that fungal superinfections may occur during or following a course of such therapy.[1,2] Long term debilitating disease, diabetes, pregnancy, corticosteroid therapy, and other causes may predispose to such fungal infections[1,3,4] as iatrogenic moniliasis. These facts complicate the administration of antibiotics.

Mysteclin-V controls both – infection and superinfection. Mysteclin-V makes a telling assault on bacterial infections and, in addition, prevents the potentially dangerous monilial overgrowth.[2,5-8] Mysteclin-V is a combination of the phosphate complex of tetracycline – for reliable control of most infections encountered in daily practice – and Mycostatin, the first safe antifungal antibiotic.

Case history after case history marked "recovered" provides clinical evidence of the special merit of this advance in specially designed antibiotics. When you prescribe Mysteclin-V, you provide "broad therapy" with extra protection that extends beyond the spectrum of ordinary antibiotics.

'MYSTECLIN'®, 'SUMYCIN'®, AND 'MYCOSTATIN'® ARE SQUIBB TRADEMARKS

Supplied:	Tetracycline Phosphate Complex equiv. Tetracycline HCl (mg.)	Mycostatin units
Mysteclin-V Capsules (per capsule)	250	250,000
Mysteclin-V Half-Strength Capsules (per capsule)	125	125,000
Mysteclin-V Suspension (per 5 cc.)	125	125,000
Mysteclin-V Pediatric Drops (per cc. – 20 drops)	100	100,000

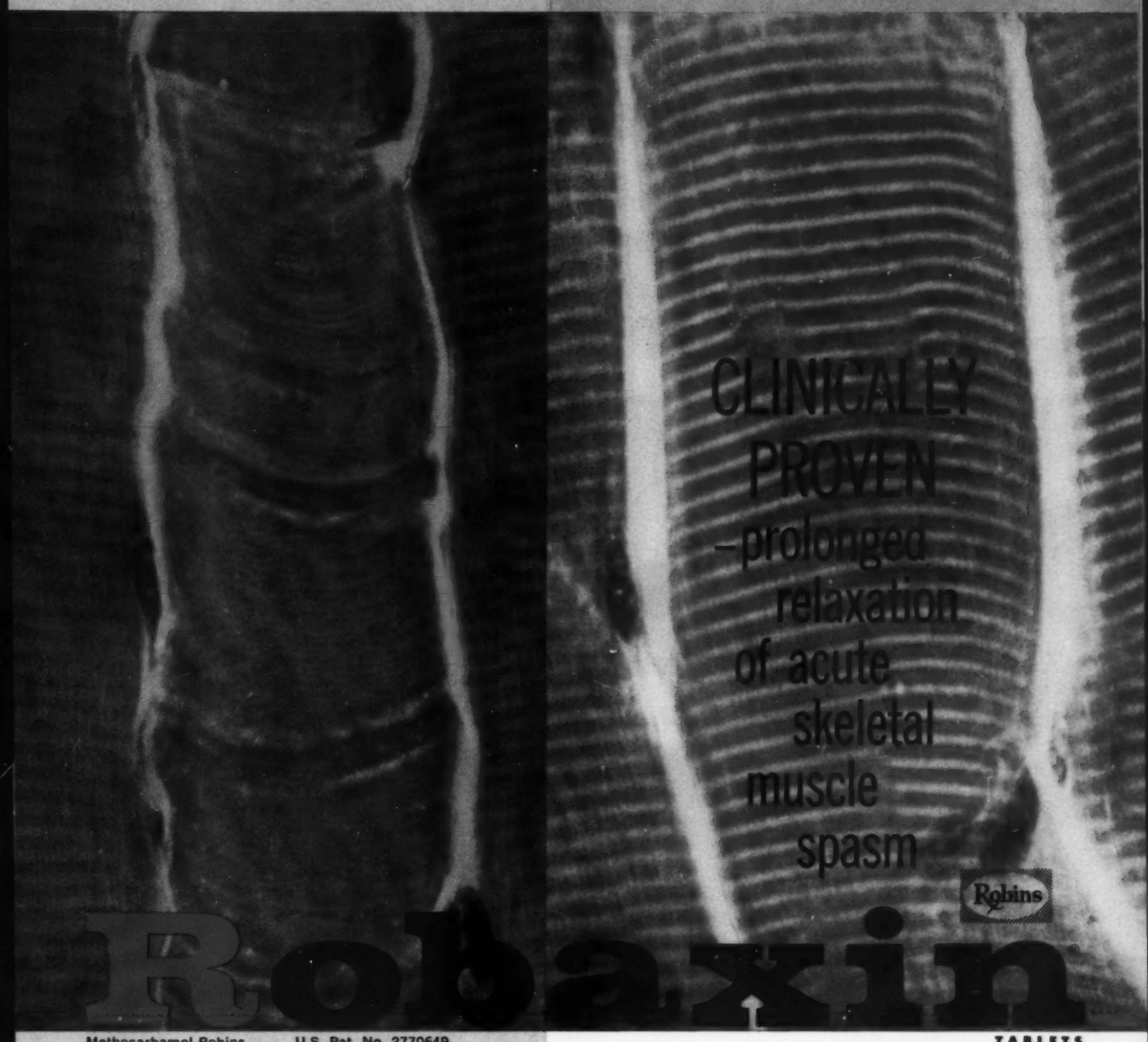
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Mysteclin - V

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SQUIBB

Squibb Quality – the Priceless Ingredient



Methocarbamol Robins U.S. Pat. No. 2770649

TABLETS

Summary of six published clinical studies:

ROBAXIN BENEFICIAL IN 92.4% OF SKELETAL MUSCLE SPASM CASES

	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
Carpenter[3]	33	26	6	1	—
		"pronounced"			
Forsyth[2]	58	37	20	—	1
		"good"			
Lewis[3]	38	25	6	—	7
O'Doherty &		"excellent"			
Shields[4]	17	14	2	1	0
		"significant"			
Park[5]	30	27	2	1	
		"gratifying"			
Plumb[6]	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- **Highly potent—and long acting.**[1,2,3]
- **Relatively free of adverse side effects.**[1,2,3,5,6]
- **In ordinary dosage, does not reduce muscle strength or reflex activity.**[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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MICRONITE FILTER:

key to Kent's popularity

During the past year, Kent sales increased by 20-billion cigarettes—the greatest gain in popularity ever recorded by any filter cigarette in any year.

Undoubtedly much of the credit for this important rise in sales must go to Kent's exclusive "MICRONITE" Filter. This extraordinary new filter was constructed to take into account new principles of filtration which were dictated by the basic discoveries of a major research foundation, working under Lorillard sponsorship.

The foundation determined that the average puff of cigarette smoke contained over 12 billion semi-solid particles. Additional research revealed that inhaled smoke from ordinary cigarettes has a predominant proportion of particles, from 0.1 to 1 micron in diameter, average 0.6 micron.

Ordinary filter fibers are so large that they create spaces through which the small semi-solid smoke particle can easily pass. However, in the exclusive Kent filter, the fibers are mechanically manipulated in such a manner as to create extremely tortuous passageways for the smoke. In this maze-like network of superfine fibers the smoke particle has much less chance to slip through the filter.

Thus, Lorillard research created a filter which reduced tars and nicotine in the "inhaled" smoke to the lowest level among the largest selling brands. As smokers learned about the "MICRONITE" Filter, they changed to Kent. During the past year, for instance, more smokers changed to Kent than to any other cigarette in America.



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Research Department
200 East 42nd Street
New York 17, N. Y.

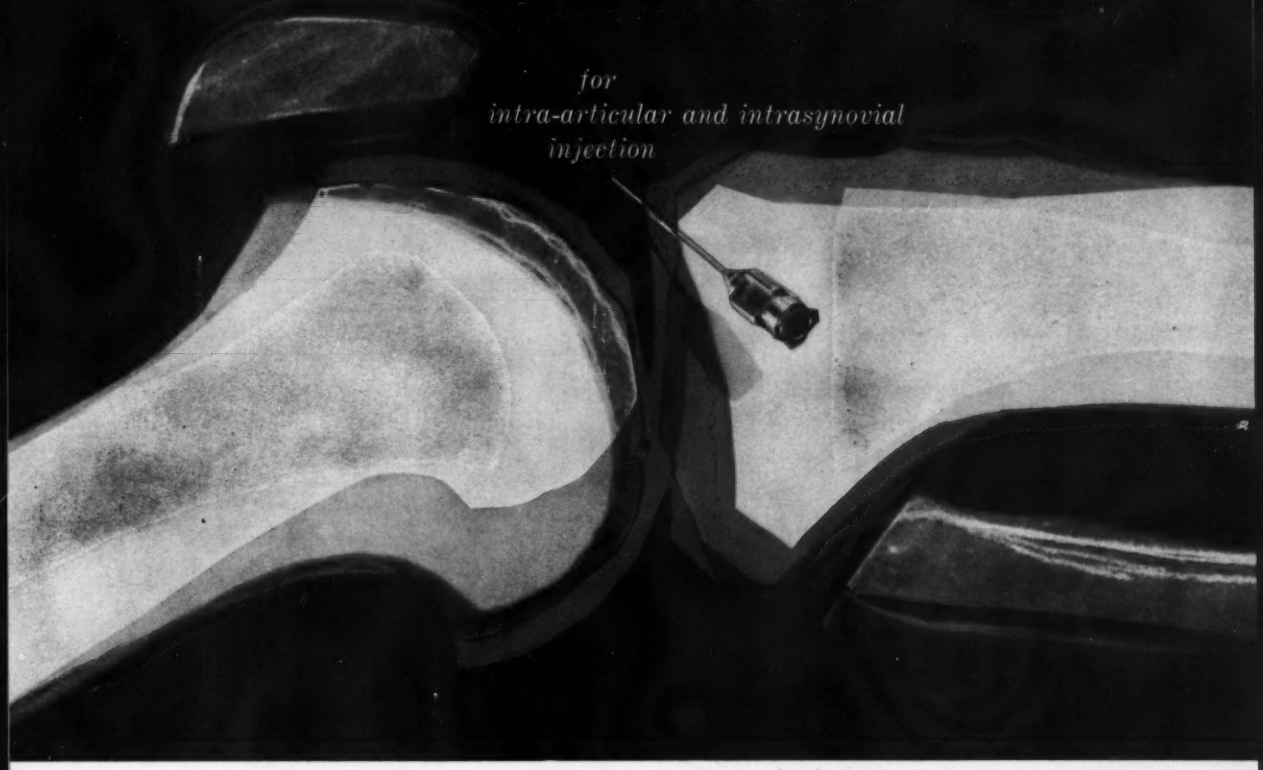
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Parenteral

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injection



for *longer* and *more pronounced* anti-inflammatory action in the *shortest time*

- when systemic therapy is contraindicated
- when systemic corticosteroids produce serious side effects
- to secure quick relief in one or two joints
- for use in conjunction with orthopedic procedures

Indications: rheumatoid arthritis; osteoarthritis; bursitis; peritendinitis; ganglion; intermittent hydroarthrosis; epicondylitis and related conditions.

ARISTOCORT Parenteral contains: 25 mg. per cc. of ARISTOCORT® Triamcinolone Diacetate micronized; polysorbate 80 U.S.P. 0.10%; benzyl alcohol 0.95%; benzalkonium chloride 0.01%; sorbitol solution N.F. 84.83%, and water for injection q.s. 100%.

All precautions required for intra-articular and intrasynovial administration of other corticosteroids should also be observed with ARISTOCORT Parenteral.

Complete information on dosage and administration is included in the package circular.

Supply: Vials of 5 cc. (25 mg. per cc.)

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

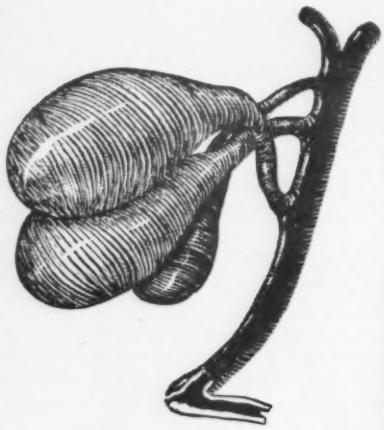
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HOW PREVALENT ARE MULTIPLE GALLBLADDER ANOMALIES?

One hundred and twenty-two cases of *vesica fellea divisa* (bilobed gallbladder) and *vesica fellea duplex* (double gallbladder with 2 cystic ducts) are reported in the literature. A unique case of *vesica fellea triplex* has recently been described.

Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



in medical management and postoperative care of biliary disorders...

"effective" hydrocholeresis...

DECHOLIN®

(dehydrocholic acid, AMES)

"...dehydrocholic acid...does considerably increase the volume output of a bile of relatively high water content and low viscosity. This drug is therefore a good 'flusher,' and is effectively used in treating both the chronic unoperated patient and the patient who has a T-tube drainage of an infected common bile duct."[1]

free-flowing bile
plus reliable spasmolysis

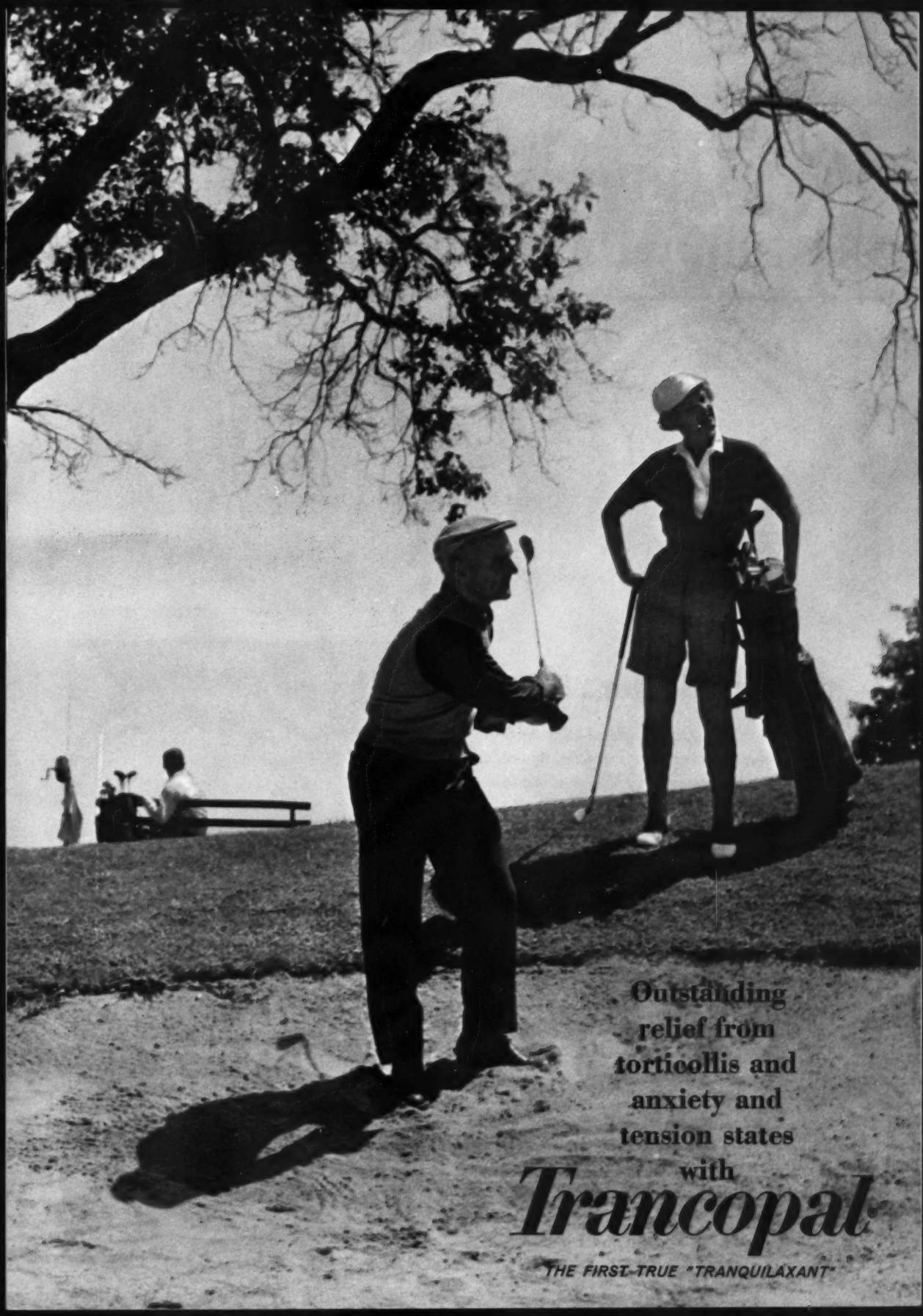
DECHOLIN® WITH BELLADONNA

"...DECHOLIN/Belladonna in a dosage of one tablet t.i.d. for a period of two to three months may prove helpful in relieving postoperative symptoms, aiding the digestion, and facilitating elimination."[2]

(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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Outstanding
relief from
torticollis and
anxiety and
tension states
with
Trancopal
THE FIRST TRUE "TRANQUILAXANT"

Here is what you can expect when you prescribe

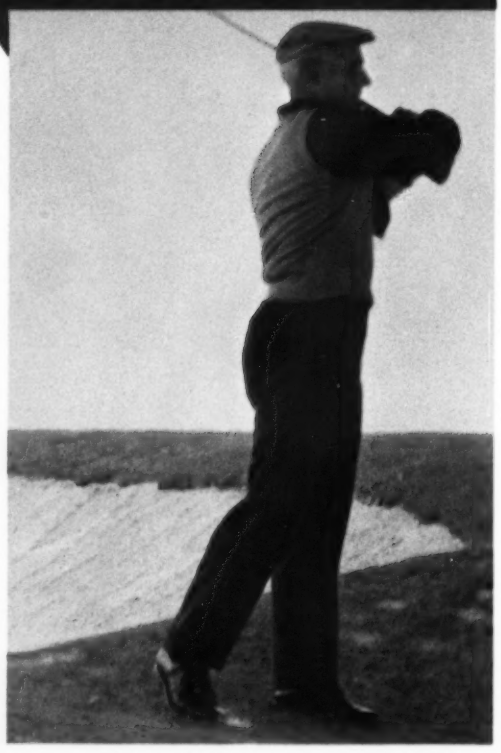
case profile no. 2840*

A 55-year-old man complained of a painful, very stiff neck on the left side. There was marked muscle spasm that seemed to involve primarily the trapezius muscle. He had a severe headache, with the pain radiating down the left side of the neck to the shoulder. There were no other findings on physical examination and results of routine laboratory tests were normal.

Trancopal was prescribed in a dosage of 200 mg. q.i.d. The first and second dose of Trancopal gave only moderate relief. However, after the third dose, there was marked relief of the stiffness of the neck, as well as the headache and shoulder pain.

After the fourth dose, medication was gradually decreased and was discontinued on the sixth day. One week later, the patient had moderate recurrence of the torticollis, and Trancopal was again prescribed in doses of 200 mg. q.i.d. The patient obtained complete relief in one day and no further treatment was required.

for torticollis



THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

for anxiety and tension states



case profile no. 3382*

A 35-year-old woman, a professional model, had an acute, severe attack of anxiety. She was irrational and unable to eat, and was very restless.

Initial medication consisted of aspirin with codeine and later meprobamate. Neither was effective, and the patient's condition became worse. She had to be hospitalized because of the marked anxiety. Trancopal was then prescribed in a dosage of 200 mg. q.i.d., in addition to bed rest.

After the second dose of 200 mg. of Trancopal, the patient became calm and rational, and was able to eat. The dosage of Trancopal was gradually reduced to 100 mg. q.i.d. on the fourth hospital day, after which the patient was discharged and was able to return to her normal occupation.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.

THE FIRST TRUE "TRANQUILAXANT"

Trancopal

***potent* MUSCLE RELAXANT**
***effective* TRANQUILIZER**

Indications:

Musculoskeletal[1]	**Psychogenic**[1]
Neck pain (torticollis, etc.)	Anxiety and tension states
Low back pain (lumbago, etc.)	Dysmenorrhea
Bursitis	Premenstrual tension
Rheumatoid arthritis	Asthma
Osteoarthritis	Angina pectoris
Disc syndrome	Alcoholism
Fibrositis	
Ankle sprain, tennis elbow, etc.	
Myositis	
Postoperative muscle spasm	

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours. The higher dosage is recommended for the treatment of patients in the acute stages of painful musculospastic conditions, and anxiety and tension states. Children (5 to 12 yrs.), 50 mg. three or four times daily.

Supply:

Trancopal Caplets®
100 mg. (peach colored, scored), bottles of 100.

New strength ▶ Trancopal Caplets
200 mg. (green colored, scored), bottles of 100.

"Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

"The effect of this preparation in these cases [skeletal muscle spasm] was excellent and prompt . . ."[3]

". . . Trancopal is a most valuable drug for relieving tension, apprehension and various psychogenic states."[4]

1. Collective Study, Department of Medical Research, Winthrop Laboratories.
2. Lichtman, A. L. (N.Y. Polyclinic M. Sch. & Hosp.): Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.
3. Mullin, W. G., and Epifano, Leonard (Long Island College Hosp.): Am. Pract. & Digest Treat. To be published.
4. Ganz, S. E. (New York, N. Y.): J. Indiana M. A. 52:1134, July, 1959.

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1. J.A.M.A., *170*:184 (May 9), 1959.

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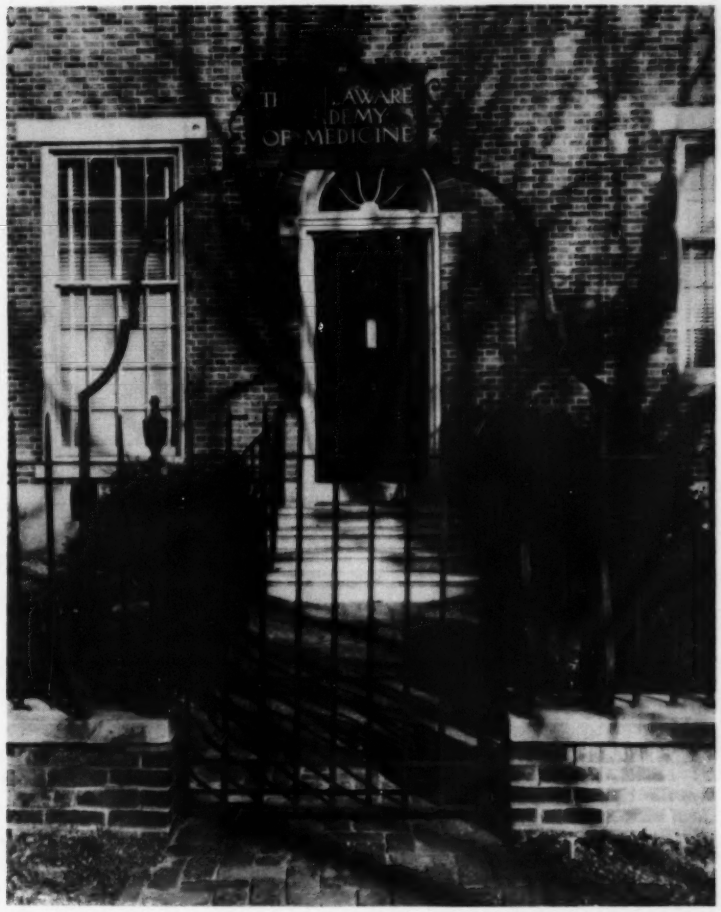
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Delaware Academy of Medicine

1925 Lovering Avenue, Wilmington, Deleware

Brick by

1930—



Bank of Delaware — The original building Market and Hanover Streets, September 15, 1883. Reproduction of a painting by John Brill McCoy.

WILLIAM H. KRAEMER, M.D.

Thirty years ago, the Delaware Academy of Medicine was just a dream in the minds of those few individuals who later became its founders. No small part of their early success was due to the one hundred and four contributors who joined them in generous gifts, making the initial step possible. The vision, fortitude and untiring faith evidenced by this original group in furthering their project, literally and figuratively built the Academy of today—brick by brick.

It was born of a need. Historically, the State of Delaware possessed a rich medical heritage. One hundred seventy years ago, through an act of the General Assembly, the Medical Society of Delaware was incorporated on February 3, 1789, with the original title of "President and Fellows of the Medical Society of Delaware". Although it has the honor of being the second oldest medical society in the United States, never through all these many years, had any satisfactory center been made available as a meeting place for Delaware's various medical and dental societies. Neither had a medical library ever been established. For any reference work, physicians found it necessary to go to the libraries in Philadelphia, Baltimore or elsewhere.

The first meeting of the founders was held on December 12, 1929, in the office of Dr. Lewis B. Flinn, who later became the first president of the Academy. Frequent meetings followed which were devoted primarily to finding a suitable site for the location of permanent quarters and plans for raising the necessary funds. The depression was rumbling at this time and tense moments came when there were doubts as to whether the project could weather this major economic disaster.

On February 19, 1930, however, the future Delaware Academy of Medicine was duly incorporated under the laws of the State as a non-profit corporation, organized for the sole purpose of fostering interest

Brick —1959



The Delaware Academy of Medicine as it stands today, Albert Kruse, Wilmington, Delaware, was the architect for the new addition.

among its members in medical, scientific, literary and educational activities and rendering service without recompense toward these ends in the State of Delaware. The Academy was on its way. The founders who had successfully guided the course of the Academy to this point appear on page 303.

About this time, by a happy coincidence, the old National Bank of Delaware building—on the corner of Sixth and Market Streets, in Wilmington was about to be demolished, having outgrown its usefulness as a home for the bank. Through the efforts of the late Mrs. Henry B. Thompson and her interest in the Society for the Preservation of Colonial Buildings, an organized movement was started to preserve this fine example of federal architecture. It had been built in 1815-1816 and housed the first bank in the State of Delaware—the fourth oldest bank in the country. With this distinguished background, the structure was ideal material for the future home of the Delaware Academy of Medicine.

A campaign was carried on and $36,000 was raised as a nucleus to finance the removal of the building, its restoration and a plot of ground for a new location.

The present site of the Academy on the Brandywine Park Drive where Lovering Avenue and Union Street meet, was purchased from Joseph Bancroft and Sons Company. This property can be traced back through the Loverings and the Shallcrosses to Thomas Gilpin, Jr., who, "on the 6th day of the 6th month in the 6th year of the reign of our Sovereign, George the Third over Great Britain, etc., and in the year of our Lord 1766", (June 6, 1766) received the land by virtue of a patent from the commissioner of property under the Honorable Thomas Penn and Richard Penn, proprietors of the Counties of New Castle, Kent and Sussex on Delaware and the Province of Pennsylvania. Thomas and Richard Penn were the sons of William Penn and his second wife, Hannah Callowhill. The tract patented to Gilpin was of 180 acres and extended southerly from the

Brandywine Creek and northerly from Rattlesnake Run.

With the exception of a few alterations for modern use, the building was erected on this site, exactly as it stood in 1816. Charles C. Cornelius, former Curator of the American Wing of the Metropolitan Museum of Art, was engaged as project architect. The English brick, mellowed to a soft tone through the years, was removed, brick by brick and reassembled at this new location. The original hand hewn rafters joined with wooden pegs, the staircase, floors, trim and the original railings surrounding the building were carefully preserved.

On June 1, 1932, a formal dedication ceremony was held and the cornerstone laid by Mayor Frank C. Sparks. The deed to the property, presented by Mrs. Henry B. Thompson to the president of the Academy, was placed in a copper box together with a roster of the Delaware State Medical and Dental Societies, a copy of the original resolutions of the Delaware Academy of Medicine, copies of medical journals, currency of that date and various clippings telling of plans for the cornerstone laying. The ceremonies were opened with an invocation by the Reverend Dr. Charles F. Penniman, then Rector of Trinity Episcopal Parish, and closed with a benediction by the Reverend J. Francis Tucker, at that time Pastor of St. Anthony's Church. Dr. William H. Kraemer presided.

The Academy found itself at this point in debt for $12,000 for the reconstruction of the building. Because the officers of the Academy were in no position to assume this financial burden, a mortgage was taken on the property and a group—formed by the officers of the Academy and interested citizens—annually raised among themselves enough money to pay the interest. Had it not been for the people who raised the money from 1932-1935 to pay the interest on the $12,000 owed to the Wilmington Trust Company, the property might well have slipped out of the hands of the Delaware Academy of Medicine. For this reason, the names comprising this group which saved the project at a critical time are recorded here Mr. Daniel F. Shields, Jr., Dr. Lewis B. Flinn, Mrs. Ernest duPont, Dr. Victor D. Washburn, Allen L. Lauritsen Company, Mr. Thomas Donaldson, Dr. Charles P. White, Dr. Charles L. Reese, Dr. Frank L. Grier, Mr. James T. Chandler, Sr., Dr. William H. Kraemer.

After this debt was paid about October 4, 1935, the deed to the property—clear of all encumberances—was signed over to the Academy. From that date, the old Delaware Bank Building became the property of the Delaware Academy of Medicine.

In 1933, the library was organized with a nucleus approximately two thousand volumes on medicine, surgery, dentistry and allied subjects. The library facilities have grown tremendously in volume in the past years. The Reading Room is inviting and maintains an impressive display of medical journals and periodicals related to medicine from all over the world.

Mrs. Ava Taylor Watson, the first librarian of the Academy, spent great thought and energy in its behalf. Her efforts were constantly directed toward facilitating use of the library to carry forward the purposes and functions of the Academy. Her untimely and sudden death was a great loss. Mrs. Edward Mendenhall very kindly stepped into the breach and acted as librarian for a period of three years. After the onset of World War II which, incidently, took into military service over 35 per cent of the Academy's membership, Mrs. Gerald Beatty acted as part-time librarian from 1942-46—a period of four years. During the war years her aid made it possible for the institution to weather the difficulties of this period. A short time after the war, the present librarian, Dr. Eugene Syrovatka, graduate of Charles University, Prague, with a degree of Doctor of Laws, was installed. His considerable banking, legal and political experience in Prague, various European countries and Mexico had finally brought him to this country. Our Government thought well enough of him to have a special bill passed

Founders



Julian
Adair, M.D.



Olin S.
Allen, M.D.



Joseph M.
Barsky, Sr., M.D.



W. Edwin
Bird, M.D.



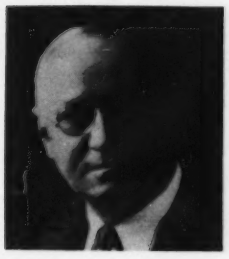
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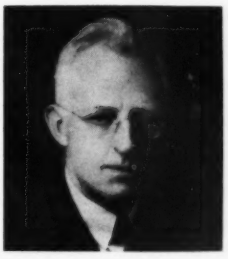
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Strikol, M.D.



Charles E.
Wagner, M.D.



Victor D.
Washburn, M.D.



The reconstructed building the old Bank of Delaware building after it was moved to Lovering Avenue and reconstructed — brick by brick.

in Congress granting him political asylum here, with the opportunity to acquire citizenship. His service and constructive suggestions have been very valuable to the Academy.

The history of the Academy of Medicine would be incomplete without mentioning the late Walter Jackson. From the very beginning of this organization he took complete charge of the building in the capacity of janitor, carpenter, plumber and superintendent and his services and personality were greatly appreciated by every member of the Academy.

Thus the Academy became the meeting place for state and county medical groups and societies; it stimulated education through its library, forums, panel discussions and symposiums, held in the auditorium. With professional and lay help, education was fostered through close cooperation with health commissions and voluntary organizations such as the American Heart Association, the American Cancer Society and similar groups.

At the meetings held from time to time in the auditorium, authorities were invited to present the latest developments in laboratory and clinical research to the assembled professions. For several years, monthly clinical—pathological conferences were given at the Academy by the pathologists of the Philadelphia General Hospital and others.

With a constantly increasing membership —which totals 312 members today—and an ever-increasing number of requests for services, it became apparent that an addition to the original building was essential. Consequently a building campaign was launched which brought the Academy contributions totalling more than $320,000 with which to plan its new facilities. This sum was made possible by 230 professional donors, 6 professional organizations and 212 lay contributors.

Plans were completed and the new addition, with added touches of refurbishing and landscaping, went into process. The auditorium has been enlarged to twice its original size. A conference room, lounge and additional office space for the Academy itself are some of the features. The basement has been equipped with kitchens and a dining room. Suitable office space has

been provided for the Medical Society of Delaware, the New Castle County Medical Society, the Delaware Diabetes Society, the Delaware Dental Society, and the American Cancer Society in the new Academy addition.

On the 14th of October, a formal dedication took place at 1925 Lovering Avenue to mark another milestone in the progress of the Academy. Guests were by invitation only and included members of the Academy of Medicine, their wives and all lay contributors including those participating in the recent campaign for the building fund. The program opened at 8:15 p.m. with invocation services by Dr. Charles F. Penniman, former rector of Trinity Episcopal Church, Wilmington. The opening remarks were given by John A. Perkins, Ph.D. Charles E. Wagner, M.D., president of the Academy, then introduced the distinguished guests who were present. This was followed by greetings from the president of the American Medical Association, Louis M. Orr, M.D. and greetings from the American Dental Association by the president, Paul H. Jeserich, DD.S. Joseph W. Ferrebee, M.D. from Cooperstown, New York, spoke on "Treatment of Radiation Casualty." The well filled, spacious auditorium more than justified the loyal service that has been rendered by both professional and non-professional Delawareans in their support of the expansion of the Delaware Academy of Medicine.

In the reception room adjoining the auditorium, bronze tablets are mounted over the fireplace, dedicated to the memory of physicians now deceased. These commemorative plaques have been given by devoted friends and patients and the generous contributions for these are applied to the endowment fund.

A second panel was erected in time for the formal opening of the new addition. It is expected that new panels willl be added from time to time to carry on the tradition.

Reviewing the history of the Academy to the present day, it is impressive to note that the faithful and painstaking efforts of the individual members, including the special contributions by some and the many generous gifts from interested friends, have made a reality of the dream—a Delaware Academy of Medicine.

Proud of its heritage, its growth and its aims the Academy has rededicated itself to the practice of better medicine by furthering medical, scientific, and educational activities.

This project must endear itself to the public, for this building—this Academy of Medicine—belongs to the people of the State of Delaware.

Presidents of the Delaware Academy of Medicine

1930 - 1959

DR. LEWIS B. FLINN, 1930 - 1941

DR. WILLIAM H. KRAEMER, 1941 - 1945

DR. EDGAR R. MILLER, 1946 - 1947

DR. GERALD A. BEATTY, 1948 - 1949

DR. BARTHOLOMEW M. ALLEN, 1950 - Sept., 1951

DR. WILLIAM M. PIERSON, Sept., 1951 - Jan., 1952

DR. LEMUEL C. MCGEE, 1952 - 1953

DR. VICTOR D. WASHBURN, 1954 - 1955

DR. ALFRED R. SHANDS, JR., 1956 - 1957

DR. CHARLES E. WAGNER, 1958 - 1959



Figure 1

Lateral view of skull showing destruction of the right frontal bone.

PRIMARY RETICULUM CELL

OF THE SKULL

JOHN S. PIENDAK, M.D.*

JOHN W. ALDER, JR., M.D.**

REPORT OF A CASE

HISTORICAL REVIEW

Until 1939, primary reticulum cell sarcoma of bone was considered to be a metastatic lesion. In 1928, Oberling suggested that this lesion had its origin in one of the marrow elements. It was not until 1939 that Parker and Jackson[1] reported a series of 17 cases of primary reticulum cell sarcoma of bone. In the same year Ewing[2] published a review of the Classification of the Registry of Bone Sarcoma and primary reticulum cell sarcoma of bone was recognized as an entity. Since 1939 there have been several large series reported. Sherman and Snyder (17 cases)[3], Coley, Higginbotham and Goresbeck[4] (37 cases) and McCormack, Ivins, Dahlin and Johnson[5] (25 cases) are the larger contributors. In none of these series was there primary involvement of the skull. Strange and deLorimer[6] in 1954 reported 3 cases of primary reticulum cell sarcoma involving the skull.

CASE REPORT

The patient was a 33 year old white married man who presented himself in October of 1950 with the chief complaint of diplopia and pain, of several weeks' duration, in the left eye. For the past three years, he had noticed a mass in the right frontal region which was slowly enlarging to include the left supraorbital area. He bumped his right frontal region with his son's head about 3-4 weeks prior to his first admission. A clinical diagnosis of osteogenic sarcoma was made at an ophthalmologic hospital in Philadelphia. He was admitted to the Delaware Hospital for surgery.

Physical examination revealed a well-nourished and a well-developed adult. BP 130/90, T. 99.0, P 80. The physical findings were limited to the head where a soft tissue tumefaction was noted in the left supraorbital area.

Laboratory findings: hemoglobin 15

*Formerly Resident, Dept. of Radiology, The Delaware Hospital, Wilmington, Delaware.

**Attending Chief, Dept. of Radiology, The Delaware Hospital, Wilmington, Delaware.

SARCOMA

WITH METASTASIS

Primary reticulum cell sarcoma of skull is a rare, radiosensitive neoplasm. When it is found, it presents a challenge to the radiologist, initially as a diagnostic problem and then as a problem in radiotherapy. The authors present a case report of an individual who has lived nine productive years after diagnosis of the initial lesion in the skull.



Figure 2

PA projection of skull showing the initial lytic lesion involving right frontal bone.

gm/100cc. WBC 9400 per cu. mm. Differential: poly 59, bands 10, lymphs 25, monocytes 4, eosinophiles 2. Total plasma protein 6.6 grams/100cc. Blood cholesterol was 198 mgm. per 100 cc. Spinal fluid chemistry, serology and cytology were within normal limits.

X-rays revealed a 4x5 cm. irregular lytic lesion in the right frontal area. A bone survey including chest, long bones and pelvis revealed no destructive changes.

Course: Operative findings revealed the lesion extending through both tables of the skull down to the dura. The lesion was incompletely curetted. The histologic diagnosis was primary reticulum cell sarcoma of the skull. From November 21, 1950 to January 15, 1951 the patient received 3,000r in air through a medium cone, 7 cm. in diameter and another 3,000r in air to the left lateral frontal area through a small cone, 3 cm. in diameter. The factors were 200 KV, 15 MA, Filter 0.5 mm. of Cu and 0.5 mm. of Al at a 50 cm.

The patient remained asymptomatic until August, 1953 when he reappeared complaining of pain and stiffness in the left shoulder for a duration of six weeks. An X-ray of the left shoulder showed a lytic lesion of the left scapula and left ninth rib. A bone survey revealed lesions of the right seventh rib, right ischium, both upper femurs and upper right humerus. He was hospitalized at another institution where physical examination revealed only a 5 x 4 cm. operative defect in the right frontal area. The laboratory findings were not significantly altered from his initial admission. In addition, his urine was negative for Bence-Jones protein. A biopsy of the left scapula showed bony tissue infiltrated by large rounded atypical cells having a fairly dense reticulum network. The diagnosis was "consistent with a reticulum cell sarcoma".

This time the patient was again treated with radiotherapy using the following fac-

tors: 200 KV, 25 MA, Filter 0.5 mm. Cu, HVL 1 mm. Cu, at a distance of 50 cm. The port sizes varied from 12 x 6 cm. to 16 x 14 cm. depending on size of the lesion. Six areas received 2,400r in air over a two week period and two areas were given 1,500r in air over a one week period. The roentgenotherapy stopped the progression of the disease in these areas and healing was noted with "scar" bone gradually replacing the lytic areas. The pain and stiffness disappeared after the roentgenotherapy to the affected areas. His daily activities were resumed without difficulty. Both physical and roentgenographic examinations are made at regular intervals and no new areas of the disease have been uncovered. The treated lesions have continued to regress and "scar" bone is noted in several areas.

This patient has lived nine useful and relatively asymptomatic years since the diagnosis of his disease.



Figure 3

Involvement of left scapula by lytic, expansile lesion, three years after initial involvement of the skull.



Figure 4

Left scapula and shows reversal of the lytic expansile process and healing with evidence of scar bone after course of radiotherapy.



BEFORE

Figure 5

Involvement of both proximal femurs and right ischium with reticulum cell sarcoma prior to radiotherapy.



AFTER

Figure 6

Note the sclerotic "scar" bone replacing the lytic areas after radiotherapy.

Comment

Primary reticulum cell sarcoma of bone is a radiosensitive lesion and is locally curable. It differs from reticulum cell sarcoma of lymph nodes in that it has a tendency to unifocal origin and this provides the basis for a more favorable prognosis. Local tumor sterilization can be achieved with minimal tumor doses of 2,000r administered with a medium volt roentgenotherapy unit. If metastases appear, the disease process can be held in check with roentgenotherapy so that the individual can enjoy a useful existence. If the disease is left untreated, it pursues the familiar relentless and ravaging course leading to death of the host.

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LYMPHOID POLYPS (Benign Lymphoma)

OF THE RECTUM AND ANUS

PATRICK F. ASHLEY, M.D.*

CALEB SMITH, M.D.*

The lymphoid polyp or benign lymphoma is a polypoid, usually sollitary, lesion of the lower rectum and anus composed of lymphoid follicles which are limited to the mucosa and submucosa. Although some writers regard the lesion as uncommon, it is frequently discovered as an incidental finding during the more routine rectal examinations now being performed for earlier cancer detection. The chief importance of the lesion lies in the recognition of its benign characteristics in spite of histological features simulating the malignant lymphomas. Thus, an awareness of its existence and nature is necessary for both pathologist and surgeon in order to avoid over-diagnosis and consequent overtreatment. It is the purpose of this article to report three cases and to present the salient features of the lesion.

REPORT OF CASES

CASE 1. A 36 year old woman during routine physical examination was found to have three polypoid tumors, each measuring approximately 1.0 cm. in diameter and situated in the rectum just above the internal hemorrhoidal area. All the tumors were excised.

CASE 2. A 24 year old woman complained of constipation, pain in the rectum and episodes of rectal bleeding over a three-month period. Rectal examination revealed hemorrhoids and a polypoid tumor 1.0 cm. in diameter above the internal hemorrhoids. Hemorrhoidectomy and excision of the polypoid tumor were performed.

CASE 3. A 41 year old woman complained of two episodes of rectal bleeding and pain. Rectal examination revealed hemorrhoids and a polypoid lesion 1.5 cm. in diameter above the internal hemorrhoid area. A hemorrhoidectomy, anoplasty, and excision of the polypoid tumor were done.

ETIOLOGY

The etiology of the lesion is not yet settled. Whereas some maintain it is a true neoplasm, the majority of investigators feel it results from a reactive lymphoid hyper-

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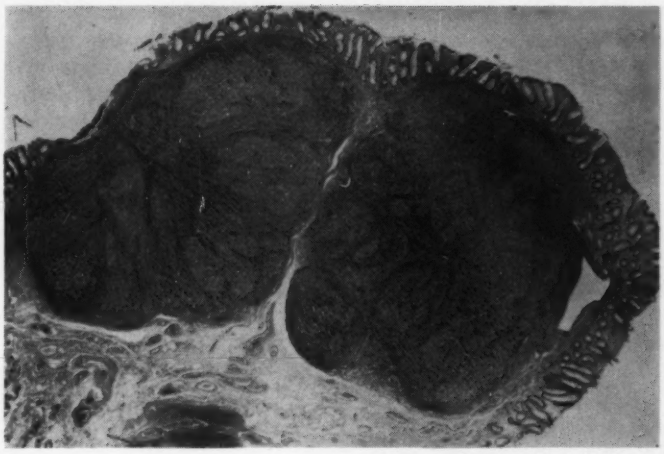


Figure 1 (H. & E. 25X) Lymphoid polyp. Note follicular structure and submucosal location.

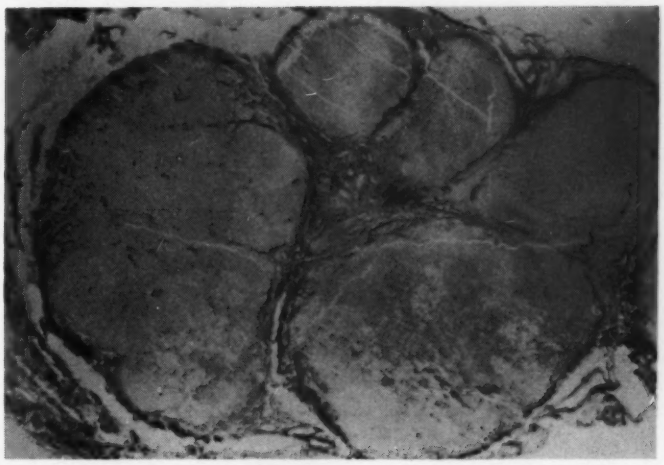


Figure 2 (Reticulum stain 25X) Lymphoid polyp. Note lobular structure

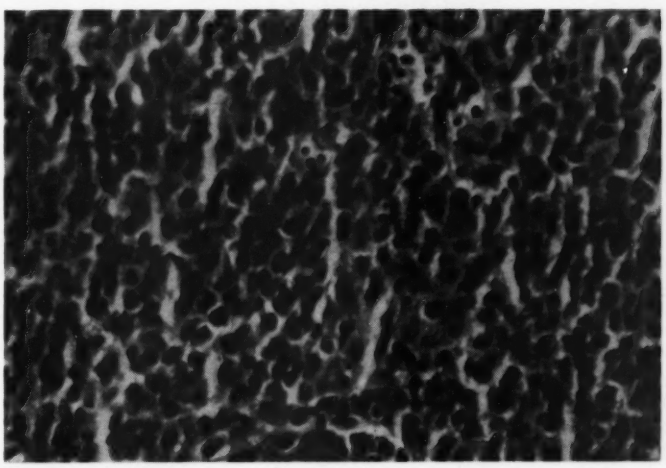


Figure 3 (H. & E. 400X) Lymphoid polyp. Germinal follicle showing phagocytic histiocytes.

plastia in response to an inflammatory (infectious, chemical, or traumatic) process within the rectum or anus.

CLINICAL FEATURES

The lesion occurs in both sexes and usually in adults. In Helwig and Hansen a series of seventy cases from the Armed Forces Institute of Pathology, the lesions were single in forty, multiple in twenty-five, and unknown in five. The majority are within reach of the examining finger.[1] They are usually felt as small submucosal nodules and are freely movable and firm in consistency. Most of the lesions are only a few millimeters in diameter. The variously described symptoms are probably due to other conditions, such as hemorrhoids, frequently found in the rectum and anus in association with the lymphoid polyp.

PATHOLOGY

Grossly, the lesion is submucosal, nodular, and sharply circumscribed. There is usually a broad case with little or no stalk. Cut section generally reveals soft, gray, homogeneous tissue.

Miroscopically, the lesion resembles a normal lymph node in having numerous lymphoid follicles with germinal centers (Fig. 1). However, there is absence of a capsule and sinusoids and the lesion is usually subdivided into lobules by delicate tissue septa. This feature is stressed by Helwig and Hansen and is well brought out by reticulum stains (Fig. 2). The bulk of the lesion is submucosal, but sometimes the overlying mucosa shows infiltration or pressure atrophy. The lymphoid cells resemble those of normal lymphoid intestinal follicles. The reaction centers frequently show mitosis and phagocytosis of nuclear and cellular debris (Fig. 3).

DIFFERENTIATION FROM MALIGNANT LYMPHOMA

Clinically, the lymphoid polyp behaves as a benign lesion and in the literature reviewed, no recurrences have occurred, and generalized malignant lymphoma has not developed. In our three cases there has been no recurrence in follow-up examinations varying from nine months to two years. Malignant lymphomas occurring in the rectum are rare and are usually a manifestation of generalized systemic involvement. Helwig and Hansen in a review of 395 patients with malignant lymphoma found the rectum to be involved in 17 instances. The histological features in these cases were those of a difluse infiltration by pleomorphic lymphocytic cells without follicle formation or reaction centers.

Occasional cases of follicular lymphoma (giant follicular lymphoma) have been reported in the rectum.[4,6] This variety of malignant lymphoma is apt to be confused with the lymphoid polyp because of the formation of follicles in both conditions. However, in follicular lymphoma no reaction centers are produced, practically no phagocytosis of cellular debris occurs, and the lymphocytic cells usually show detectable pleomorphism.

In all varieties of malignant lymphomas occurring in the rectum, the muscularis propria is frequently invaded. As stated previously the lymphocytic cells in the lymphoid polyp do not extend beyond the submucosa.

SUMMARY

The lymphoid polyp (benign lymphoma) of the rectum and anus is a benign lesion and should not be confused with the malignant lymphomas. As the term lymphoma is now invariably used synonymously with malignant lymphoma, it appears advisable to drop the designation benign lymphoma and to refer to this innocent lesion of the rectum and anus as the lymphoid polyp.

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THE LIVING TRUST FOR DOCTORS

● A Living Trust is created by transferring property, securities or cash to a trustee under a trust agreement. The income may be payable to the maker of the trust or to anyone he names and may end at any designated time—at his death—or may continue beyond that point for the beneficiary named. The author sets forth the advantages of this type of trust fund to those engaged in the medical profession.

LEONARD S. HOLE

Vice President and Trust Officer
Farmers Bank of the State of Delaware

Is it the doctor's training to rely upon his own education, experience and judgment in the practice of his profession that makes him averse to delegating his non-professional tasks to others? There would seem to be no other explanation to the generally accepted statement that doctors are poor business men.

It must be conceded that a material improvement has occurred during the past thirty years. Before World War I, the writer of this article helped pay his way through law school by collecting doctor bills. In those days, the doctor's bookkeeping arrangement usually consisted of the bottom drawer of his desk in which were stuffed hastily drawn memos—upon which were written a date, a name with address and the hoped-for fee. Today, nearly every doctor maintains a complete set of books and someone trained in keeping them. The income tax has been responsible for this improvement.

But while the doctor has become a better business man by delegating the task of keeping the money coming in, he has not fully realized that he needs more than a bookkeeper or an accountant, no matter ho wefficient, if the estate he is accumulating is to be protected for his own retirement and for his wife and children in the event of death. To this end, he should have a talk with the Trust Officer of his bank.

To many people, trust service of banks is limited to acting as Executor or Trustee under Wills. They do not realize that a large portion of their business is devoted to handling the financial affairs of living persons under a form of agreement known as the "Living Trust." There is no group of people to whom this service can be of greater value than the men and women engaged in the medical profession.

The Living Trust is always a tailor-made instrument, with such provisions for the distribution of income and principal, as may meet the needs and wishes of the maker of the trust, the Trustor. While there are many types of Living Trust with different income tax, gift tax and estate tax consequences, this discussion of the subject will be limited to the type of greatest interest to doctors, the Revocable Living Trust.

To create a Living Trust, the Trustor assigns and delivers to the selected bank or trust company—cash, securities and sometimes real estate. The trust agreement outlines the duties and powers of the Trustee and the powers retained by the Trustor. Sometimes the Trustee is given unrestricted powers to sell and purchase securities. Sometimes the Trustee is required to obtain the Trustor's consent. The trust is amendable and revocable at any time. In most cases, the Trustee is directed to pay the entire net income to the Trustor himself though another beneficiary or other beneficiaries can be named.

One may ask how the Living Trust as above described differs from an agency and what advantages are obtained through the Living Trust.

An Agency terminates at the death of the owner of the property. A Living Trust continues after the death of the Trustor for management and distribution of the income and principal as provided in the trust agreement. Thus, the Living Trust Agreement acts as a Will insofar as the trust assets are concerned.

There are three advantages to be obtained by having a Living Trust continue after death:

1. The trust never becomes a public document as in the case of a will, so that the provisions made for one's family are completely confidential.
2. Since administration fees allowed to an Executor or Administrator is dependent upon the value of personal property passing through administration and since property passing by means of a Living Trust, does not pass through administration, the saving in administration expenses of the estate is substantial.
3. There is no delay in transferring the benefits of the trust from the original beneficiary to succeeding beneficiaries. Property passing through administration usually requires from nine months to a year before legatees and beneficiaries under Wills can receive the amounts to which they are entitled.

The following are questions frequently received concerning Living Trusts together with the answers:

Q. How small a trust will a trust company accept?

A. A few trust companies set a minimum but the general practice is to accept any trust where a real need for one exists. It can be quite small provided the Trustor plans to make additions to it from excess earnings.

Q. How does a bank or trust company invest small trusts?

A. Most banks with trust departments maintain, under constant supervision of the Trust Committee, a Common Trust Fund,

which is a large investment account containing both stocks and bonds. Interests in this Fund can be purchased at the net asset value for the smaller trusts which will give them the diversification so necessary for conservative investment.

Q. If a trust should exceed $100,000.00, *what investment program would the bank follow?*

A. That would depend upon the general economic and market outlook at the time. Other factors would be considered such as the need of the beneficiary or beneficiaries for income.

Q. Can the Trustee be directed to accept a certain investment philosophy with relation to the trust?

A. Yes, as long as the Trustor is willing to relieve the Trustee of all liability if loss should result therefrom.

Q. What are the legal requirements for the investment of trust funds in Delaware?

A. Delaware has adopted the "Prudent Man" rule. In other words, there are no restrictions regarding the type of investment; the only requirement being that the Trustee invest as a prudent man would do in investing his own estate.

Q. Are there any tax savings to be obtained by establishing a Revocable *Living Trust?*

A. Not unless the trust continues beyond the life of the first one named as income beneficiary after the death of the Trustor. No estate or inheritance taxes will be due when that beneficiary or succeeding beneficiaries die.

Q. Are there any tax savings obtained by establishing an Irrevocable *Living Trust?*

A. Yes. An irrevocable trust for the benefit of someone other than the Trustor is a gift, and if it exceeds the annual exclusion and lifetime exemption, will be subject to the Gift Tax. The income, however, is taxed to the beneficiaries instead of the Trustor. The trust assets will not be included in the Trustor's Estate at his death. This usually makes for a considerable tax saving.

Q. What is the Short Term Living Trust and what are the Income Tax consequences?

A. When a trust is irrevocable for 10 years or longer or for the life of the Beneficiary, who is not the Trustor, the income is taxed to the trust, if income accumulates, or to the beneficiary if the income is distributed, and not to the Trustor. Trusts for charities need be irrevocable for only two years to receive this tax treatment.

Q. Does the bank or trust company keep a complete record of all receipts and disbursements and a record of the cost of securities and the dates of purchase?

A. They do even more. They will furnish annually, a complete statement of all items to be included on one's income tax return. This saves the listing of individual stock dividends and the breakdown of gains and losses on the sale of securities.

Q. Will a Revocable Living Trust qualify as a Restricted Retirement Trust under the Jenkins-Simpson Bill now before Congress?

A. When and if this bill is passed, permitting those self employed to contribute a limited amount of income annually tax free to a Restricted Retirement Trust, the trust can be amended so as to qualify.

Q. Is trust service expensive?

A. The rates charged in Delaware usually follow the schedule adopted by the Court of Chancery. Rates, starting at 5% of the income decline as the size of the trust increases. It should further be remembered that trust commissions are a deductible item on the income tax return of the Trustor. It is never a question of whether one can afford the service, but whether one can afford to do without it. The savings, in time, to the doctor is worth many times the cost of the trust. How else can he be free to devote all the time demanded by his profession, and also enjoy periods of leisure and vacations, assured that his financial affairs are under the constant supervision of a responsible bank experienced in these matters!

AN INDICTMENT OF HATE*

● This is a case study — an indictment of hate hurled against the home environment and milieu of a rebellious and resentful teenage girl.

SHELDON W. WEISS, Ph.D.**

We shall call the subject Judy. Judy was referred to the Mental Hygiene Clinic through the information services of the Mental Health Association. The reason for the referral stated: "Sexually promiscuous, very poor relationships with peers, expelled from school because of truancy." Judy received a thorough psychiatric evaluation which included psychological testing and counselling by the author.

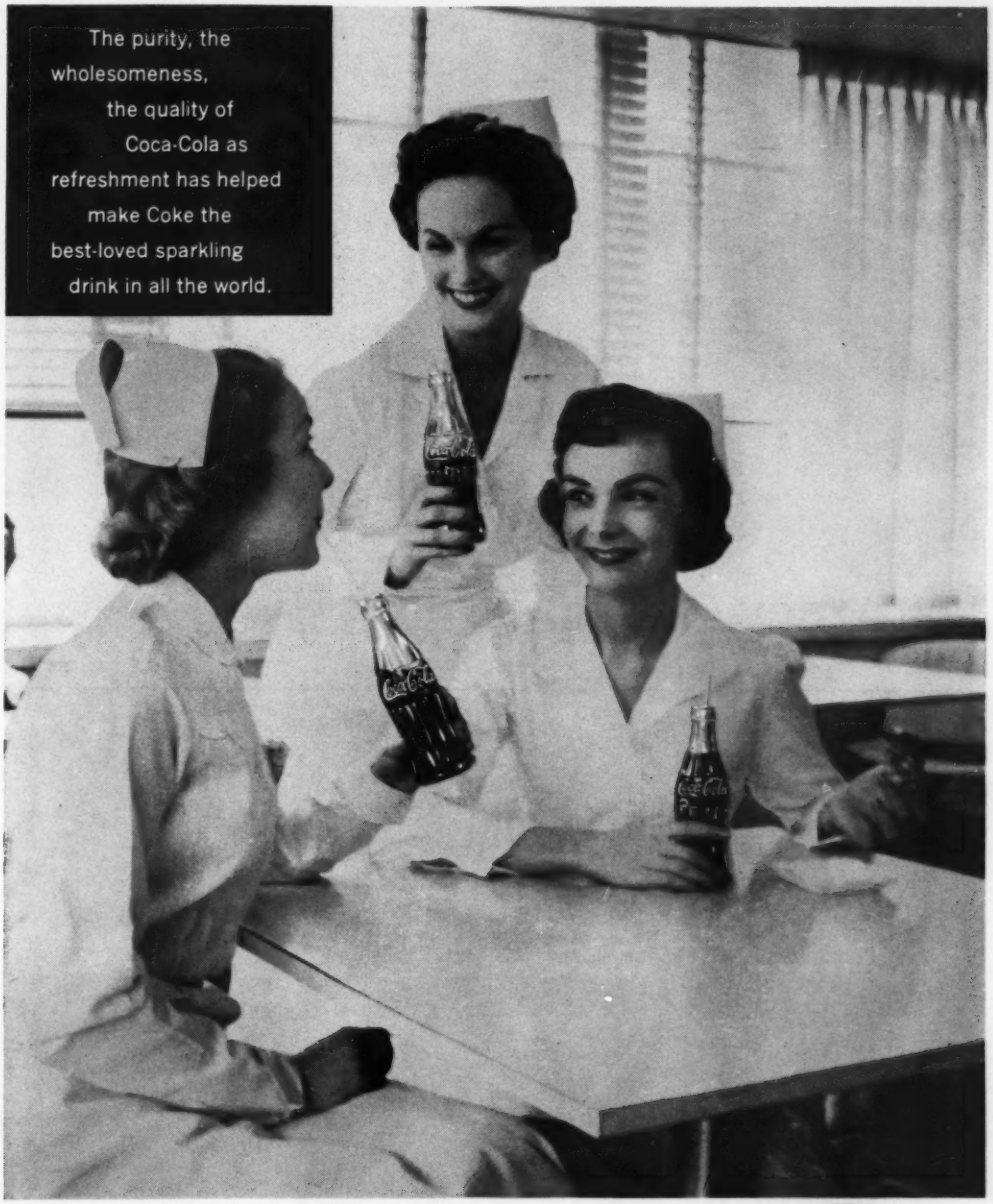
At the time of referral Judy was seventeen years old. Two months prior to the referral she had been relocated at the home of her brother and sister-in-law and their two children because her brother felt "Judy might improve if she was away from our parents' home."

Judy informed the psychiatric social worker that she had engaged in sexual relations with an eighteen year old boy when she was fourteen years of age. She stated that she had known the boy for only a month and had felt terrible after the episode. A year later a second sexual act occurred with a sixteen year old boy whom she had known for only a week. There were two more such events in the following two years. It was noted that the subject engaged in these relationships with four different males and was not approached a second time by any one of the boys. The social worker observed that "Judy appeared bothered more by the fact that she was not sought out again by the same male than she did concerning her actions."

Judy's history revealed that her familiar relationships were distant and erratic. She stated that her father was never close to her and that he was "distant and cold." Her father appeared to be a strict disciplinarian with Judy's two older siblings but was "un-

*The names and events have been altered to insure anonymity.

**Chief Clinical Psychologist—Delaware State Hospital & Mental Hygiene Clinic.

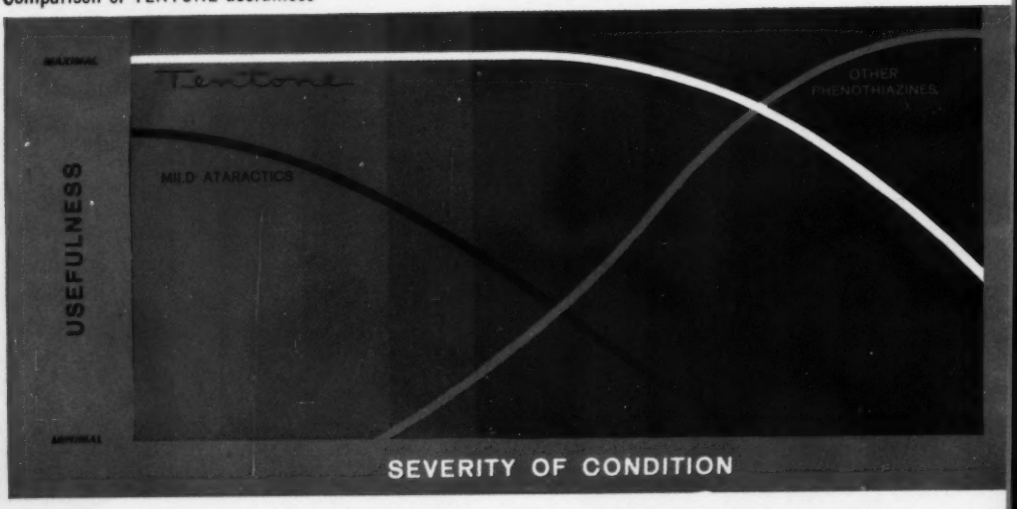


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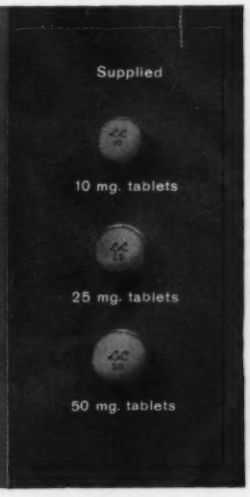
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interested" in Judy. After discovery of her sexual conduct, the father became belligerant, almost totally rejecting her. Judy claimed that her mother was "old fashioned like my father." She added that her parents always wanted her to be refined and to sit at home and be a young lady. Judy attended parochial school through the ninth grade from which she was expelled because of truancy, misbehavior and general disinterest in academic work.

The results of the psychological examination disclosed:

> *". . . The subject made a poor physical and social appearance, appearing much underweight for her stature. Her clothing appeared somewhat shabby and ill-fitting. Her hair was uncombed and unkempt. . . Intellectually the subject appeared to be functioning in the average, normal range, achieving a Full Scale I.Q. of 102. There were no test signs of any gross cardinal organic impairment or dysfunctioning. The projective material disclosed a pattern of gross immaturity, dependency and social inadequacy. The subject did not appear to be making constructive use of her potentialities. There was much self-doubt and uncertainty displayed with marked ambivalent feelings towards important personages in her environment. Emotionally the subject appeared somewhat out-going and labile with marked tendencies toward impulsivity and acting-out of aggressive impulses. Evidence of moderate anxiety was present which the subject appeared to minimize through verbal expression of contempt for her surroundings and for those she views as responsible for her plight. Reality testing was fairly well maintained and ego-strength appeared sufficient to hold her destructive wishes and impulses in check. Both her performance on the tests as well as during her psychological examination, evidenced much confusion, inner disharmony, immaturity and marked feelings of inadequacy. . ."*

After being seen by the psychiatrist, Judy was diagnosed as an Adjustment Reaction of Adolescence with the recommendation that she receive therapy at the clinic. Because of the possibility of endocrine dysfunctioning, Judy was seen by the endocrinologist who reported: "Weight: 82 pounds, height 61½ in. Thyroid is negative. Pulse and pressure normal. Musculature moderate, generally lean. General nutritional state is substandard and thin. PBI and Blood Cholesterol within normal limits." A dietetic regime was instituted.

Psychotherapy was commenced four weeks after her initial contact with the clinic. At the onset, Judy posed her critical questions: *"Why do I act like I do"?* and *"Why do I hate so much"?* It wasn't until several months of therapy had transpired that she began to answer some of these questions for herself. On the fifteenth session Judy reported to the clinic with an autobiography that she had written during the previous week. It contained the following material:

> ". . . I suppose I could tell from being around my parents that they were very displeased with me, like I was their daughter and they were stuck with me. It seemed to me that I got the attention I needed but never the love I craved. I always did and still do believe that they felt sorry for me. Then I can remember that I also thought they had adopted me, that I didn't really belong to them. I wonder also if I was born a crippled child because quite often as I got older my father always used to say: "Oh you old cripple," and I would shout back in tears: "I am not, you bitch.' '
>
> I used to be very happy when we had company because they seemed to be glad to see me, they seemed interested in my actions. I felt very unloved and unwanted and unneeded. Whenever I would want to help my parents with anything around the house, I would get turned down either by one of my father's witty wisecracks or my mother's "Oh, but you're so delicate" refusal. It took quite a bit of time to get my shell hard enough so no one would know the real me. I was bold as my mother would say. In the seventh grade I began to smoke and I don't know how many tons of cigarettes I smoked. I knew I was being bad but I didn't care any more, not about anything. That's what I wanted to believe. Underneath I was a hurt little child that I thought nobody could love. Not even a little bit. I suppose as a child I was always bored; not just sometime but all the time.
>
> I had a bike but never rode it; skates but never skated. I only wanted to be loved by somebody. I suppose when I was real young I wanted my parents' love, but as I got older and saw I wasn't getting theirs, I suppose I would look to anybody to love me. I never seemed to have any playmates. They always made fun of me because of the funny way I walk. But I said to myself that I hated them all. Then I went to school and got bored with that. I was always looking for someone to

care for me and when nobody cares about you, you begin to hate and fight back. My mother was always buying things for me, as a matter of fact, it seems now that both my mother and sister were always competing to see who could buy me more things. Now when I look back I can see where I didn't want what they could buy me, all I wanted was their love and you can't buy that with money. I never think I've done anything that I really wanted to do. My parents or sister were always telling me what to do. They ruled me with an iron hand and I reacted to them with hate. They tried to teach me responsibility but you can't teach anything without kindness.

I guess I'm afraid of things that other people do because I don't do them myself so I feel like an odd-ball. I want to be like other people but so many times I feel I'm lazy and don't really want to help myself. I guess all these years I've gotten to learn that if nobody cares about you then what's the use of caring about yourself. You see, I guess when you get right down to it I'm just a scared little girl who could never really admit it to myself or to others. I always felt I must have been stupid, not capable of helping myself because if I admitted I needed someone else's help, then I couldn't help myself. All I ever really learned to do with my life is hate.

I hate myself, my parents, my sister, in fact, I hate everything. I hate everything I ever did because it was stupid. My parents must have thought you grow up like a machine, needing only gas and oil and no love. Now they're all watching me and criticizing me and blaming me for what they really caused. They didn't have the time to love me and care for me when I needed it but after I have already destroyed my self-respect and pride, then they all come running and screaming their heads off "Oh, you poor child, we must help you." Why couldn't they help me when I needed it?

Sexual relations, four, five or how many times, I don't care who knows about it. Everybody called me a prostitute and maybe I am. Maybe a prostitute is more than I ever was or ever will be. I suppose I didn't care what they called me. I begged for their love but they were always too busy to pay attention to me. All they cared about was themselves, expecting me to be seen and not heard. It's taken me seventeen years to get here to finally begin to understand myself. . ."

Having been able to bring out and discuss this vital, emotionally charged material, Judy proceeded to make rapid gains in her treatment. The hate that she felt towards her parents, siblings and peers gave way to understanding, tolerance and love. The immature ideas of love based on attention and selfishness were replaced with a genuine feeling for people and ideals as well as an increased feeling of self-esteem and respect. I think Judy found *her* answer.

DON'T BE A "HACK," SAYS SAVANT

The private practice of medicine, a tradition every thinking person wishes to secure and perpetuate, rests fundamentally on the freedom of the physician to practice the art and pursue the science of medicine free of any outside influence. *Rear Admiral H. G. Rickover*, father of the atomic submarine, gave emphasis to this in a recent address at the Stevens Institute of Technology when he said:

"Service ceases to be professional if it has in any way been dictated by the client or employer. The role of the professional man in society is to lend his special knowledge, his well-trained intellect, and his dispassionate habit of visualizing problems in terms of fundamental principles to whatever task is entrusted to him. Professional independence is not a special privilege but rather an inner necessity for the true professional man, and a safeguard for his employers and the general public. Without it he negates everything that makes him a professional person and becomes at best a routine technician or hired hand, at worst a hack."

Newsletter, California Medical Association

SUB-COMA INSULIN TREATMENT

In Delaware State Hospital

AYDIN Z. BILL, M.D.*

Although there is a generally accepted definition of deep coma insulin therapy, the concept of sub-coma insulin treatment is not very clear. Kalinowski and Hoch describe sub-coma as "practically the same as Phase I of insulin shock treatment." The concept of Payne Whitney Psychiatric Clinic of sub-coma is "the level in which the patient barely responds to one or two strong noxious stimuli, and does not respond to any weak stimuli." Rennie defines it "with the production of somnolence and clouded consciousness, the treatment stopping just short of loss of consciousness and stupor phenomena." Sargant and Slater, as explained under the title of "*Modified Insulin Therapy*", terminate the treatment with a maximum of 100 units—"provided that the patient is still able to eat the food given him at the end of three hours." According to Laqueur, "*The criteria of percoma is when a patient is dizzy, slightly confused, displays cold sweat and tremor, but still can be reached by calling his name or by mild pain stimuli.*"

While the definition is not clear, the terms used for sub-coma insulin treatment differ greatly, such as "modified insulin treatment", "half coma", "precoma", "ambulatory insulin treatment", "light coma", "superficial coma", and "stupor".

We give insulin treatment primarily to achieve mild and moderate states of hypoglycemia. As is universally known, this produces many changes in the vegetative functions reflected in a decrease of tension and anxiety also in increase of weight. In our insulin treatment war, we bring the patient to the verge of coma, reaching a level between the end of Stage I, and the beginning of Stage II. The dosage of insulin used in order to achieve this level, differs widely for each patient; however, the effective doses range between 10 and 230 units.

The clinical response is quite characteristic and similar to that defined by many authors. As the first symptoms of hypoglycemia appear, the patient displays profuse perspiration, salivation, hunger, thirst, parasympathetic and sympathetic hyperactivity following each other in waves. Within two and a half hours the patient shows difficulty in thinking, hypotonia, impaired alertness and confusion. Responses to stimuli become increasingly inadequate and patient displays slurred speech. Motor manifestations vary from mild twitching to grand mal convulsions. The patient may

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laugh or cry loudly, exhibit apraxia, aphasia, loss of speech, and manifests a decreased response to strong stimuli. At this stage we terminate the treatment.

TECHNIQUE

During the treatment all patients are kept in one room. The room is kept in semi-darkness, in silence, and the patient at complete rest. Before the treatment each patient had been gone over thoroughly to make sure there were no contraindications to the treatment. Insulin injections are given intramuscularly at 7:00 a.m. Termination of the treatment is at 10:00 o'clock sharp. At this time the ward physician who is assigned to insulin treatment, evaluates the patient's response in order to determine the dosage for the next day. Patient's food intake at every meal is carefully supervised and the patients are kept under close supervision to prevent the occurrence of delayed reactions in the afternoon or evening.

At the time of termination of the treatment, the patients receive a very light breakfast, consisting of coffee, fruit juice, and two slices of toast with either butter or jam. We stress the importance of breakfast being light so that the patient does not lose his appetite for the main meal at noon. Patients are encouraged to eat between meals and these are recorded too.

A daily treatment, and weekly weight charts are kept. On it are shown half-hourly records of pulse, the amount of insulin and glucose given each day. Accordingly, the time of desired level of treatment and the time of termination are also recorded. We give full treatments on five days a week, and the treatment continues for eight weeks. Every Saturday morning the patient is interviewed to evaluate the progress of the treatment.

The starting dose of insulin therapy is 10 units, and the dosage increased by 10 units daily until the desired level is achieved. When this level is reached, it is kept in that stage. Due to the fact that some patients become more sensitive to insulin as the treatment progresses, it is sometimes found necessary to reduce the dose 10 units each day. In one of our patients we found that when the insulin dosage was decreased to 10 units, the patient was still very sensitive and was on the verge of coma. This patient is one of our two cases who did not receive any benefit from this treatment.

We usually terminate the treatment by giving 480 cc. orange juice with glucose, orally. In some cases, when the patient seems unable to take anything by mouth, the treatment is terminated by 50 cc. 50% glucose given intramuscularly. None of our patients need more than the above to gain full consciousness.

After the noon meal, the insulin patients are encouraged to participate in all activities on and off the ward.

In some cases we combined sub-coma insulin treatment with electroconvulsive treatment, or a neuroleptic drug, such as Thorazine or Compazine. The results in these cases were very encouraging.

MULTIPLE DOSE TECHNIQUE

In four of our cases under treatment at the time this article was written, we applied multiple dose technique as described by Laqueur and LaBurt.

In the first case the patient was put on a straight dose technique as described previously, and although the dose was increased up to 230 units daily, the patient remained very calm, relaxed, responding verbally, and was not perspiring at all. Then, on the fourth week of the treatment, we changed to multiple doses, starting 20 units at 7:00 o'clock, 20 units at 7:15, and 20 units at 7:30. The next day patient received 30 units at 7:00, 20 units at 7:15, and 20 units at 7:30. Patient became drowsy, and perspired moderately. We continued to increase the doses 30-30-20, 30-30-30, and finally to 40-30-30 at the above time intervals. On one occasion when the patient received 100 units with multiple dose method, she became very drowsy, and

subsequently displayed involuntary sucking reflexes. She did not respond to strong pain stimuli (supra-orbital pressure). Patient was not able to take any drink by mouth and treatment terminated by giving 50 cc. 50% glucose intravenous.

The second patient was rather sensitive to insulin. A single dose of 100 units of insulin was enough to bring this patient to the verge of coma. On the third week of her treatment we gave multiple doses beginning with 10 units at 7:00 o'clock, 10 units at 7:15, and 10 units at 7:30. Although she received 70 units less than her regular daily dose, she went into coma and her treatment had to be terminated with 100 cc. 50% glucose given I.V.

The third patient's response was similar to the above patient's; however, in the fourth patient the multiple dose method proved to be very potent, while a single dose up to 220 units daily produced a very slight reaction.

During thee sixth week of the fourth patient's treatment, we switched to the multiple dose method beginning with 20 units at 7:00 o'clock, 20 units at 7:15, and 20 units at 7:30. Patient then began to display profuse viscid perspiration, salivation, her eyes became fixed, and she responded only to strong painful stimuli. Her treatment was terminated by giving 50 cc. 50% glucose I.V. and the next day insulin dosage was reduced to 20-20-10 units. The patient again passed into the second stage, this time with excitation and agitation. Treatment was terminated with 100 cc. 50% glucose given I.V. and it was decided to change her treatment with the single dose method because she was extremely sensitive to the multiple dose method.

In the case of our four patients the multiple dose technique proved to be more effective than single doses and required approximately only half of the amount of insulin used in the single dose method.

With the multiple dose method, termination time of treatment was changed to 11:30 a.m. Patients' meal time was also changed in the following manner: they had their lunch at 12:00 o'clock, dinner at 5:00, and a snack at 8:00 (using Laqueur's method).

Cases

In acute and subacute wards of Delaware State Hospital, we have treated seven patients with sub-coma insulin treatment, during the last six months. Five of the seven patients were clinically improved or recovered enough to be sent home. Two of the patients did not show any favorable response except a gain in weight.

Case I:

This was a 37-year-old married woman, who was admitted to Delaware State Hospital in August 1951 for the first time in a catatonic excitement state. Initially she was treated with electro convulsive therapy (ECT) and after ten treatments she was put on deep insulin coma therapy during which she received 58 treatments with 25 comas. She was discharged in March 1952, after staying in the hospital for eight months. Her second admission came in April 1956. This time she was mute, appeared withdrawn, catatonic and negativistic. Under sodium amytal, patient still refused to talk. It was reported that the patient had not been eating for seven days. Intravenous feeding had been started to prepare the patient for electro convulsive treatment. After her second treatment she began to talk about some of her difficulties encountered during her psychotic episode. In June 1956 she was put on a course of Thorazine treatment, 150 mg. per day. At the end of the same month, she was sent home under the supervision of the Home Care Program. She continued to take her medication, but in November 1956 she refused to take Thorazine any longer. Six months later she was admitted to Delaware State Hospital for the third time. She was in a catatonic stupor. She was negativistic, mute, and resisted any attempts to open her eyes. She was put on electro convulsive treatment, and after the fourth treatment started to talk. She was put on a course of Thorazine again, and in a very short time she showed a good adjustment and proficiency in her duties. Six months later she was sent on Trial Visits, from which she returned in a catatonic stupor on January 24, 1959. She was mute, refused to eat, resisted any attempts to open her eyes, and lay in a statue-like position. This time she was put on combined sub-coma insulin treatment and electro convulsive therapy. In the first week of her treatment, she regained consciousness, cooperated fully with the treatment, and was very cheerful and exhibited a good sense of humor. She was discharged as recovered after being in the hospital only four months.

Case II:

This was a 19-year-old married woman who was admitted in December 1958, three months after the birth of her child. Her diagnosis was Schizophrenic Reaction, Catatonic Type. She was very excited, shouted loudly, and was completely unmanageable. Upon admission she was put on a course of electro convulsive treatment, but after the fifth treatment it was discontinued due to deterioration of her condition. She became extremely excited, overactive, and unmanageable. Then a course of Compazine treatment was started, 25 mg. t.i.d. At first there was a very marked improvement, but at the end of four weeks, the patient developed marked extrapyramidal symptoms, and because she became extremely excited, aggressive, hostile, and hallucinated, drug therapy was therefore discontinued. In this case both treatments, ECT and Compazine, failed all the way. In February 1959, she was put on sub-coma insulin treatment and in March 1959, Thorazine 100 mg. t.i.d. was added. Since the termination of insulin treatment, patient has remained quiet, cheerful, cooperative, and well adjusted to the ward and her duties. At the present time she is under the supervision of the Home Care Program.

Case III:

This was a 21-year-old unmarried girl, who was admitted for the first time in November 1956, and her diagnosis was given as Schizophrenic Reaction, Schizo-Affective type. Following her admission she was put on a course of electro convulsive treatment. After the eighteenth treatment she developed a great deal of confusion which lessened in about a week, yet patient was not entirely clear then. Later on she became somewhat depressed. One month later she had begun to show some more definite improvement and was referred for individual psychotherapy. She was discharged in March 1957. She was admitted the second time in January 1959, and in February 1959 she was put on sub-coma insulin treatment. On completion of this treatment she was more cheerful, and was no longer preoccupied with ideas of guilt or ideas of impending harm or disaster. She was eating and sleeping well, and was taking a greater interest in her appearance. She was working actively in office work, and showed a little more spontaneity than previously. She was no longer fearful, nor entertained any of her former delusions. She was discharged as recovered four months after her admission.

Case IV:

This was a 30-year-old married woman who was admitted in October 1958. Her diagnosis was given as Schizophrenic Reaction, Schizo-Affective Type. Following her admission she appeared depressed, somewhat negativistic and uncooperative. She was afraid of various people and was hallucinated. She was put on electro convulsive treatment which was discontinued due to deterioration of her condition, after the eleventh treatment. She was then put on a course of MK-130 treatment, 200 mg. t.i.d. After a short period of recovery, her depression and worries increased markedly. She was then put on sub-coma insulin treatment. Her treatment was completed recently. Since the end of her treatment, she has shown some definite improvement inasmuch as her mood has now become stable, consistently pleasant and cheerful with disappearance of the numerous doubts and preoccupations she had showed previously. She is far more organized than before and is no longer fearful.

DISCUSSION

Although many authors feel that there is a positive correlation between the depth of insulin treatment and a favorable response in the presented four cases of Schizophrenia, we have found that the patients benefited to a large extent from sub-coma insulin treatment where some new drug therapies and electro convulsive treatments have failed. As shown in the case of the first patient, the result of deep coma insulin treatment combined with electro convulsive therapy, and the result of sub-coma insulin treatment combined with electro convulsive therapy are practically identical. It should also be noted here that although electro convulsive treatment combined with Thorazine did help the patient, the remission was a very brief one.

In the two patients who were suffering from schizophrenic reaction, Schizo-Affective type, where electro convulsive therapy (ECT) is the treatment of choice, they either showed no improvement or were made worse. However, as it was pointed out above, they profited from the sub-coma insulin therapy.

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MEDICAL LICENSURE

IN THE STATE OF DELAWARE

ANDREW M. GEHRET, M.D.*

Contrary to generally accepted opinion, the Delaware State Board of Medical Examiners does not grant licensure for the practice of Medicine within the state. According to the Laws of Delaware which regulate the practice of medicine—as amended in 1955—the Organization structure includes the Medical Council of Delaware and the separate body known as the State Board of Medical Examiners.

The Medical Council — the parent body — consists of three members: the President Judge of the Superior Court of the State; the President of the State Board of Medical Examiners; and the third, a member of the Medical Society of Delaware, who is not a member of the State Board of Medical Examiners.

The Governor of the State appoints the ten members of the State Board of Medical Examiners from a list of resident members of the Medical Society of Delaware submitted by the Society's House of Delegates. Two members and three members are appointed in alternate years as terms of four years expire. The present Board of Medical Examiners contains six members from New Castle County, and two each from Kent and Sussex Counties.

However, it is the Medical Council of the State which grants licenses to practice medicine upon recommendation by the State Board of Medical Examiners.

The Medical Council and the State Board of Medical Examiners operate in close harmony under the philosophy that the health of the citizens of the State of Delaware is a sacred trust.

The two bodies recognize that it is their duty to limit licensure to competent physicians, and also to throw no roadblocks into the path of demonstrably outstanding physicians who wish to practice in Delaware, providing that there is no circumvention of the state laws.

Written examinations are availablle twice each year in the months of January and July. Applicants for licensure by reciprocity, or endorsement of a medical license from another state, are interviewed personally in the same months. The State of Delaware does *not* recognize a certificate from the National Board of Medical Examiners as such.

For endorsement, Delaware will recognize the license of any state in the Union as

*Member Executive Committee, Federation of State Medical Boards of U. S. and Delaware State Board of Medical Examiners.

long as the applicant meets the requirements of this state. These state requirements are not a 'gimmick' on which to base refusal, but rather a program to maintain high standards. One of the 'musts' for all applicants is United States citizenship.

Insofar as reciprocity from Delaware is concerned, this state enjoys a cordial relationship with a great majority of the other states. Florida, which has its own peculiar problems, recognizes no license from another state.

Certain states, which have Basic Sicence Laws, require successful completion of this examination before endorsement of an out-of--state medical license.

For Delaware to endorse an out-of-state medical license, an applicant must have practised at least two years in the state from which he wishes reciprocity.

The Medical Council of Delaware, in order to encourage physicians of high calibre to locate in this state, has established the following policy: Hospital resident physicians in a specialty, desiring endorsement for a license from another state, may designate this period of residency training as time in practice if they have completed the prescribed residency training for the specialty and are American board eligible in their chosen field.

In a recent issue of one of the national magazines, there appeared an article by a physician who boasted of having acquired licensure to practice medicine in thirteen different states, by the process of endorsement. In the past, the Medical Council of Delaware has denied reciprocal licensure to individuals who merely wanted a license, but gave no reasonable indication of moving into the state.

By far the greatest problem is presented by the graduate of a foreign medical college. Incidentally, Canadian colleges of medicine are accepted on a par with their American counterparts. It is readily obvious that several hundred colleges of medicine throughout the rest of the world can not be satisfactorily evaluated by the board. By Delaware law, a graduate of a foreign medical college must present irrefutable evidence of the following:

1. United States citizenship.
2. Satisfactory service as an intern in an acceptable American hospital.
3. Residence in this state for a period of at least one year.
4. A Degree from an accredited American Medical College.

In recent years, the Medical Council has included a fifth requirement:

5. *Successful completion of the American Medical Qualification Examination.*

Compliance with qualification number five assures interested parties that the foreign medical graduate has met certain minimal requirements. They are:

1. Has had his educational credentials evaluated by the Educational Council for Foreign Medical Graduates and has been found to meet minimal standards.
2. Has a command of the English language, both oral and written, quite adequate for the work of an intern in an English-speaking hospital.
3. Has a sufficient knowledge of medicine and the basic medical science to justify assuming an internship in an American hospital.

The Delaware State Board of Medical Examiners is a member of the Federation of State Boards of the United States. There is a yearly meeting of the Federation which is attended by a representative of the Delaware Board. Four years ago, the Federation established State Board Examination Institutes. These Institutes are open discussions among the representatives of the various State Boards at the annual Federation meeting. They are led by nationally recognized teachers in the clinical and basic science subjects. The object is not so much to standardize the examinations in the various courses as it is to have the examiners keep pace with the advancements made in modern medicine.

A side product is to further eventual recognition of all licenses from any and all states; i. e., the State of Iowa need have no fear of incompetency in accepting for endorsement a license from the State of Delaware, and vice versa.

For fuller and better understanding, during the course of the Federation's first Institute, medical education was divided into three levels:

1. Academic; completion of medical college.
2. Internship.
3. Specialty training.

It is felt that State Board examinations for medical licensure should test the applicant for his ability to assume responsibility and his fitness to practice general medicine. This would seem to adjust the level of the various examinations to the second category; the completion of the internship, rather than medical school knowledge or the more highly technical specialty training.

In recent years, wide-spread attention has been attracted to the cost and length of time required for attaining the degree of Doctor of Medicine. In at least one center, a program is under way in which the number of years and the resultant financial outlay by the candidate will be curtailed without impairment of quality of education. Delaware state licensure laws will not conflict with this program.

The foregoing is an accurate statement of the policies and actions of the Medical Council of Delaware and the State Board of Medical Examiners. From personal communication with representatives from other similar organizations, the writer feels that the activities of the Delaware Council and Board are at least on a par with those from other states.

DIABETES DETECTION DRIVE

The Annual Detection and Education Drive of the Delaware Diabetes Association is held the week before Thanksgiving. This year, a special effort will be made to surpass the 3,890 cases examined last year. Physicians, hospitals, and allied professions, as those of nursing, pharmacy, dentistry and chiropody, are again asked to take part. The State Board of Health will lend valuable assistance. Schools and service clubs and other organizations will cooperate.

Kent and Sussex Counties have been asked to join New Castle County in the Drive, through committees appointed by the respective presidents of the County Medical Societies.

Chairman of the Drive for Delaware is Dr. Leonard Tucker. Mr. Abel Klaw, President of the Lay Society will motivate his Detection and Education Committee, side by side with the Clinical Societies' group for this purpose.

Information may be received concerning the Drive by calling the Association's office in the Academy of Medicine, Olympia 2-2413. Please leave your name and phone number.

Remember the dates of the Drive this year — November 15 to 21.

Editorials

THE ACADEMY —

October, the month in which we dedicate the new building of the Academy of Medicine, is the month of that great American game—football. The Monday morning papers will contain big headlines of brilliant runs by the halfbacks and strategy of the quarterbacks. Equally important, but relatively obscure, are the hardworking linemen without whom the runs would be impossible.

The Academy may in general be likened to the above situation. Late in 1957 under the superb quarterbacking of President Shands, the problem of needed expansion was met. The fact that we are dedicating the building this month speaks for the fact that the line held, the blockers did their work, and the *team* scored.

President Shands deserves great credit. The sixteen founders—our All American—backed by the 312 members and last, but far from least, our many friends can look with pride upon this achievement.

POLITICS vs. THE PUBLIC WELFARE —

As we go to press, Delaware is faced with two problems in which the will of the General Assembly seems to be at variance with what is best for the people.

The first problem is relatively small but obvious. Due to lack of funds, mosquito control has been curtailed during 1959. Within 100 miles in the neighboring state of New Jersey there has been a serious outbreak of encephalitis, a disease allegedly transmitted by certain species of the mosquito. Let us hope that the General Assembly will see to it that 1960 finds Delaware protected.

The second problem is larger and, in terms of people affected, more important. In 1955 the office of Medical Examiner was created. A qualified physician was obtained from an outstanding institution. This man knew the problem in Delaware and had the ability to correct some of our deficiencies. Progress has been slow; mistakes undoubtedly have been made. There has been no question but that a system where investigation of medico-legal problems by a qualified physician is better than one utilizing only the services of a politically elected lay coroner. In May, 1959, the Sussex County Medical Society unanimously passed a resolution supporting the system of Medical Examiner.

In the same month the Delaware State Funeral Directors Association unanimously supported the same system. Similar expressions of support have come from the Delaware State Police and other law-enforcement agencies,—and from the daily press.

If the office of Medical Examiner ceases to exist, it will indeed be a sorry day.

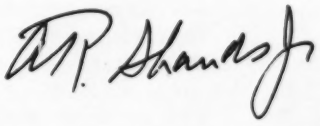
President's Page

During the third week in September, your President performed one of the pleasant duties of office—the paying of official visits to our three county medical societies. A brief report was made to each society on the plans for the Annual Meeting and on a few of the key activities of the State association during the past year. These visits he made in one afternoon and two evenings, losing only the afternoon hours from his office. How strange this must sound to the president of a larger state society who might start in the beginning of a term of office to visit component groups and by the end of the year, with many, many days spent in this official duty, may not have had time to visit all of the state's county societies.

Our geography is such that an institution such as the Welfare Home at Smyrna is hardly more than an hour's drive from any point in Delaware; yet, probably the citizens of no state in the union are more acutely aware of the differences within state borders than Delawareans.

In a way this is quite justifiable. The economy and approach to living of New Castle County's "chemical capital" and Kent and Sussex Counties' "broiler capital" involve different problems and produce different ways of doing things. With the rapid development of our hospitals in lower Delaware in the last twenty years, one should wonder, though, if the differences in the medical communities of New Castle and those of Kent and Sussex are as pronounced as some have thought them, and really if there are any actual dissimilarities. During the visits to the Kent and Sussex Societies, your President sat and talked with those practicing radiology, anesthesiology and pathology in hospitals located in smaller communities; hospitals which formerly used to be closely associated with metropolitan hospitals. The departments of these specialists are naturally smaller than those of big hospitals, but the quality of service is unquestionably excellent and the volume of the work is entirely adequate to meet the patient loads.

As professional people with similar education, activities, and ideals, we should think more about what we have in common and less about the diminishing differences in our community practices. The county societies should and certainly will always retain their identities as local groups dealing with local problems; but empathy, or the understanding of the other man's problems, on a broader basis, which has not always been ours in the past, offers rewards, professionally and otherwise, that as physicians we owe ourselves to develop more fully.



President, Medical Society of Delaware

In Brief

F.A.C.S.

At the 1959 convocation of the American College of Surgeons held in Atlantic City, October 2, the following Delaware physicians, all from Wilmington, received the distinction of being inducted as Fellows of the world's largest organization of surgeons:

Dr. C. Davis Belcher, Dr. Edgar N. Johnson, Dr. Donald G. McHale, Dr. Edwin K. Mehne and Dr. Bayard R. Vincent.

Our Growing Population

Hospital cases for 1958 in the U.S.A. rose 700,000 over 1957, the AHA reported. Each day last year there were more than 1,300,000 patients and 48,000 newborn babies in hospitals. The Health Insurance Institute figures show that childbirth is the largest major reason for the hospitalization of women today.

Longevity or The Moon

In a Heart Research Newsletter, published by the American Heart Association, statistics prove that 654 Americans, when given a choice, would vastly prefer to spend money for medical research than put the first man on the moon. In the poll recently conducted by the Michigan Survey Research Center, the tally was: 54% in favor of "a new program for medical research;" 32% for "new approaches to juvenile delinquency;" 7% for "basic research and sciences such as chemistry and physics;" and only 3% for "putting the first man on the moon." Note: The average life expectancy in the Western World has increased 20 years since 1901, due to medical research.

Tribute 1866-1959

Abraham Flexner more than any other layman, was the man responsible for building up the nation's medical schools. His endowment of Johns Hopkins and subsequent development of that medical school as the finest of the period, reshaped medical education and created a sweeping reorganization in other medical schools throughout the United States. We are indebted to him today for this country's unparalleled standing in the field of medicine.

This Brave New World

At the first open forum of Atoms and Us in Highlands School, Wilmington, Dr. Floyd I. Hudson, executive secretary of the State Board of Health, was a member of the panel, and described fallout studies made by the Board of Health in its work for the detection and control of fallout and radiation danger. Water, waste and air samples are constantly being taken by the Board for radiation tests. It is believed that this program will increase public understanding of the dangers.

All the Tea In Japan

Two Japanese scientists in their experiments with mice, claim that tea acts as an antidote to the effects of strontium 90, the tannin absorbing and carrying away as much as 90% of the dangerous isotope.

"The World . . . Late and Soon?"

"High living standards," claims George Bugbee, President of the Health Information Foundation, "are probably associated with the current high level of heart disease; high industrial development seems to be associated with respiratory conditions and definitely, high speed transportation has increased the number of accidents and fatalities."

Heart Fund's R.F. Program

Free medicine for the prevention of rheumatic fever is available to the indigent R.F. patient at four hospitals in the State, according to Dr. Robert L. Dewees, President of the Delaware Heart Association.

The physicians in charge of these clinics are: Beebe Hospital, Dr. Arthur Tormet; Kent General Hospital, Dr. John Lazzeri; Delaware Hospital, Dr. David Levitsky; Wilmington General Hospital, Dr. Herman Rosenblum.

Dr. Rosenblum is chairman of the Rheumatic Fever Prevention Committee of the Delaware Heart Association.

Monkey "Chop Chop"

Sir Ronald Fisher of Cambridge University, England, writes in Industrial Medicine and Surgery that monkeys will eventually replace human workers on the factory assembly line if brain surgery followed by intensive speech training is effective. Sir Ronald sees monkeys of the future puttering around private homes as butlers, valets and servants. *Editor's note: Being ahead of Sir Ronald, we have already noticed these phenomona.*

Third in the Nation

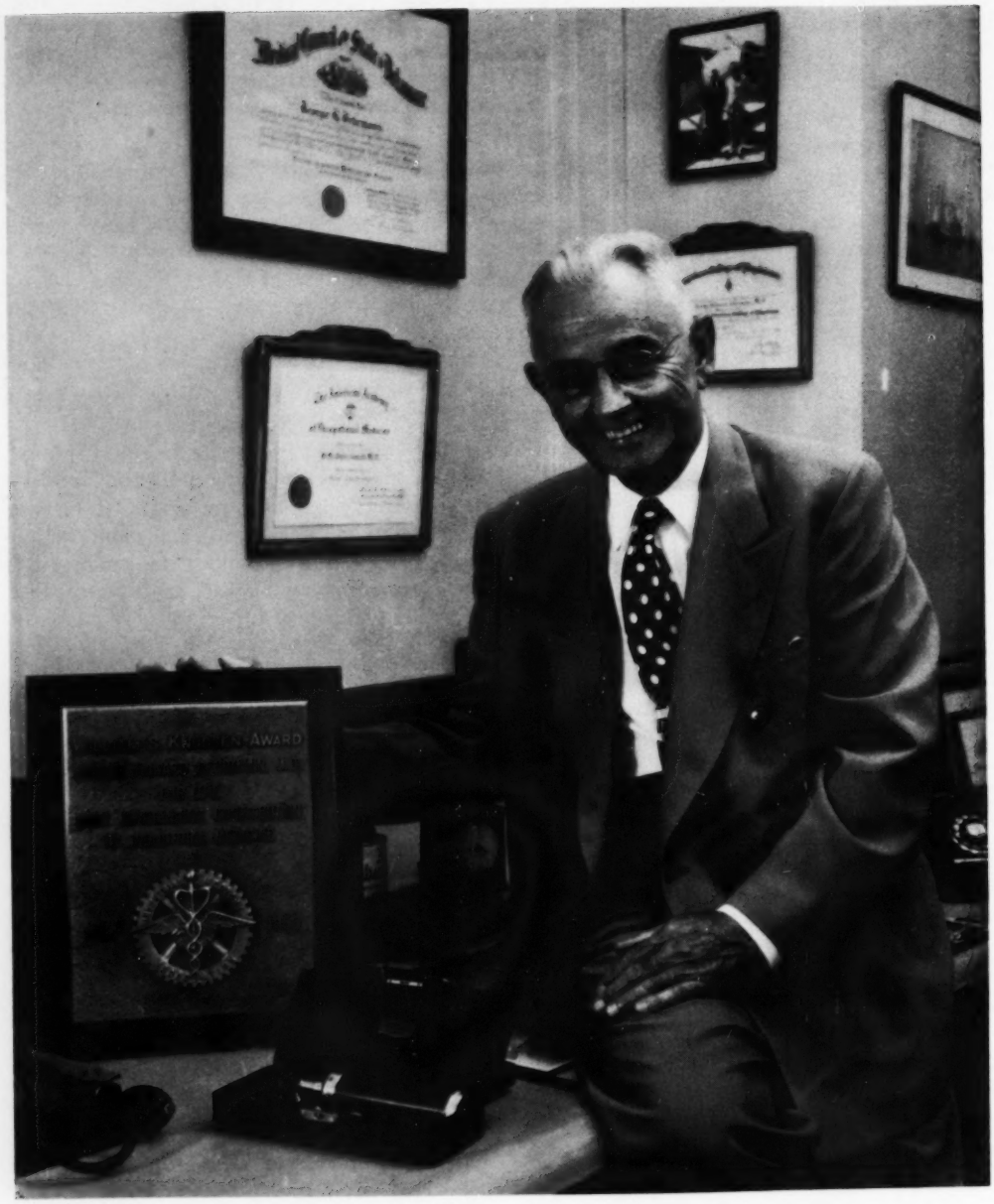
Delaware ranks third in its rehabilitation program for the fiscal year 1958 out of the 53 states and territories which operate a similar program carried on jointly by the State and Federal Government. Delaware rehabilitated 116 persons per 100,000 population — Georgia was first with 146 and West Virginia second with 118. Delaware's Vocational Rehabilitation Division has continued to show an increase each succeeding year.

Reports show that physicians were the largest single source of referral, accounting for the referral of one out of every three persons rehabilitated. With the national average cost of rehabilitating a disabled person around $600, figures prove that it is more costly to maintain a person in idleness or in an institution. In Delaware, the average cost per rehabilitant this past year was $496. This could be termed as an investment as it is estimated that for every dollar spent on his rehabilitation, the disabled worker pays back $10 in Federal income taxes during his period of employment.

Mass Casualties Course

Two spaces for civilian physicians are open for the Course on Management of Mass Casualties being conducted at the Walter Reed Army Institute of Research, Washington, D. C., February 15-20, 1960. These have been made available to the A.M.A. Council of National Defense by the Office of the Surgeon General, Dep't. of the Army.

Physicians interested in attending are requested to write directly to the Council on National Defense, A.M.A. Association, 535 Dearborn St., Chicago 10, Ill.



GEORGE HOWARD GEHRMANN, M.D.

1890 - 1959

GEORGE HOWARD GEHRMANN, M.D.

1890 - 1959

Dr. George H. Gehrmann was born in Norwalk, Connecticut on October 11, 1890 and died at Fairville, Chester County, Pennsylvania on September 3, 1959. He received his M.D. from the Long Island Medical College in 1913 and served his internship in the hospital associated with that institution. He joined the duPont Company in 1915, served in the Army in World War I, and became Medical Director of the duPont Company in 1926. He retired in 1955.

Dr. Gehrmann has been a member of this Society since 1927. He was a Fell ow of the American College of Physicians and the American Public Health Association. He was the first president of the American Academy of Occupational Medicine of which he was a co-founder in 1946. The Academy has since instituted an annual series of lectures known as the *George H. Gehrmann Lectures.* He was a member of the Persident's Committee on Employment of the Physically Handicapped, a member of the Advisory Board of the Greenbriar Clinic, White Sulphur Springs, West Virginia, and a member of the Board of Directors, Memorial Hospital, Wilmington.

In 1955 he received the William S. Knudsen Award of the Industrial Medical Association for meritorious service in the field of industrial medicine. In 1956 he received the Alumini Medallion for Distinguished Service to American Medicine from the State University of New York College of Medicine, New York City. In 1956 he also received the Distinguished Service Award of the Medical Society of Delaware in recognition of the honor he brought to the Society through his pioneering and valuable contributions in the field of occupational medicine.

The above is but a sketch of the honors received by Dr. Gehrmann; honors reflecting the esteem in which he was held by members of his profession as well as the public. There is no doubt that it was largely due to his efforts that occupational medicine now enjoys a respectable place in the medical profession.

A person is indeed fortunate if it can be said that he left the world a better place because of his having lived. Had he done nothing in his 69 years other than his work in the rehabilitation of alcoholics, his contribution to society would have been great. George Gehrmann's spirit will live in this work that he, alone, began.

Books

New acquisitions to the Library of the Delaware Academy of Medicine from January, 1959 to the present time.

In bringing its book list up-to-date, the Library would like to review the library rules for the benefit of those using its facilities.

Books, journals and periodicals may be taken out by members of the Academy only — for a period of twoo weeks. Extension time may be granted if there has been no request for the same material by another member. Upon request, any material will be mailed to members residing outside of New Castle County. Dictionaries, directories and material for reference must be used in the Reading Room. Cards notifying the borrower of an expired date are mailed, allowing one week of grace. Fines are imposed beyond this period.

The Library is also open to the public. The Librarian, however, reserves the right to supervise the selection made in the Library by this group.

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CHART OF PARLIAMENTARY PROCEDURE

No.	Motion	May interrupt speaker?	Must be recognized?	Must be seconded?	Debatable?	Amendable?	Vote Required?	Renewable?	Reconsiderable?	May apply to following motion?	Motions that apply to it?	Yields to?	Roberts Par.	Roberts Pg.
	PRIVILEGED (in order of rank)													
P 1	To fix time to which to adjourn	No	Yes	Yes	No	Yes	Majority	Yes - but for different time	Yes	None	S 6 U 2	None	59	16
P 2	To adjourn	No	Yes	Yes	No	No	Majority	Yes	No	None	None	P 1	60	17
P 3	To recess	No	Yes	Yes	No	Yes	Majority	Yes	No	None	None	P 1, 2	64	18
P 4	Question of privilege	Yes	No	No	No - but resulting motion is	No	Decided by chair	Yes	No	None	None	P 1, 2, 3	66	19
P 5	Call for order of the day	Yes	No	No	No	No	None	Yes	No	Any order	None - except to postpone orders	P 1, 2, 3, 4,	68	20
	SUBSIDIARY (in order of rank)													
S 1	To table	No	Yes	Yes	No	No	Majority	Yes	No	P 4, 5 - MM I 1 - U 2	None	P 1, 2, 3, 4, 5	104	28
S 2	To move previous question	No	Yes	Yes	No	No	2/3	Yes	Yes	Any debatable motion	U 2	P 1, 2, 3, 4, 5 S 1 I 1-11	111	29
S 3	To modify debate	No	Yes	Yes	No	Yes	2/3	Yes if lost	Yes	Any debatable motion	U 2	P 1, 2. 3, 4, 5 S 1, 2 I 1-11	118	30
S 4	To postpone to a definite time	No	Yes	Yes	Yes Limited	Yes	Majority - if special order 2/3	Yes	Yes	P 4 MM U 2	S 2, 3, 6 U 2	P 1, 2, 3, 4, 5 S 1, 2, 3 I 1-11		
S 5	To commit or refer	No	Yes	Yes	Yes Limited	Yes	Majority	Yes	Yes	P 4 MM	S 2, 3, 6 U 2	P 1, 2, 3, 4, 5 S 1, 2, 3, 4 I 1-11	125	32
S 6	To amend	No	Yes	Yes	Yes	Yes	Majority	No	Yes	P 1, 3 S 3, 4, 5 MM - I 6, 9	S 3, 6 U 2	P 1, 2, 3, 4, 5 S 1, 2, 3, 4, 5 I 1-11	134	33
S 7	To postpone indefinitely	No	Yes	Yes	Yes	No	Majority	No	Yes - only by "aye" side	P 4, 5 MM	S 2, 3 U 2 (aye side only)	P 1, 2, 3, 4, 5 S 1, 2, 3, 4, 5, 6 I 1-11	152	34
MM	MAIN MOTION	No	Yes	Yes	Yes	Yes	Majority	Not at same session	Yes	None	All	All	51	11
	INCIDENTAL (no rank)													
I 1	To Appeal from Decision of Chair	Yes	No	Yes	Certain Appeals	No	Majority	No	Yes	Any decision by chair	S 1, 2, 3	P 1, 2, 3, 4, 5 S 1	81	21
I 2	To withdraw a motion	No	No	No	No	No	Majority	Yes	Negative vote only	Any motion	U 2	P 1, 2, 3, 4, 5 I 1	100	27
I 3	To suspend the rules	No	Yes	Yes	No	No	2/3	No - except by unanimous consent	No	Any motion	None	P 1, 2, 3, 4 S 1	83	22
I 4	Point of order	Yes	No	No	No	No	Chair decides	No	No	Any motion or act	None	P 1, 2, 3, 4, 5 S 1	78	21
I 5	To make a Parliamentary inquiry To request information	Yes If urgent	No	No	No	No		No	No	Any motion	None	P 1, 2, 3, 4, 5	98	27
I 6	To divide the question	No	Yes	No	No	Yes as to proper division	Majority	Yes	No	MM S 6	S 6	P 1, 2, 3, 4, 5 S 1, 2, 3, 4, 5 I 1-11	89	24

I 7	To divide the assembly	No	No	No	No	No	Majority to order a count	Yes	No	Any motion	None		95	25
I 8	Objection to consideration	Yes	No	No	No	No	2/3	No	Negative vote only	P 4 MM	U 2	P 1, 2, 3, 4, 5 S 1-11	87	23
I 9	To close nomination	No	Yes	Yes	No	Yes time only	2/3	Yes if lost	No		None	P 1, 2, 3, 4, 5	96	26
I 10	To consider seriatum	No	Yes	Yes	No	No	Majority	No	No	MM	None	P 1, 2, 3, 4, 5	92	24
I 11	To read a paper	No	Yes	Yes	No	No	Majority	No	Yes		None	P 1, 2, 3, 4, 5 I 1-9	101	27
	UNCLASSIFIED (no rank)													
U 1	To take from the table	No	Yes	Yes	No	No	Majority	Yes	No	Only to tabled motion	None	P 1, 2, 3, 4, 5 I 1-11	154	35
U 2	To reconsider	Yes for entry only	No	Yes	Yes If original motion is debatable	No	Majority	No - unless by general consent	No	except Any motion P 2, 3, 5 - S 1 I 3 - U 1, 2	S 1, 2, 3, 4	P 1, 2, 3, 4, 5 S 1-11	156	36
U 3	To rescind	No	Yes	Yes	Yes	Yes	2/3 if previous notice - majority	Not at same session	Yes negative vote No affirmative vote	Any motion	S 1-7	P 1, 2, 3, 4, 5	169	37
U 4	To ratify	No	Yes	Yes	Yes	Yes	Majority	No	Yes	Any motion	All	P 1, 2, 3, 4, 5 I 1-11	173	39

THE MEDICAL MEETING

"What Do I Want To Do?"

INTRODUCE BUSINESS?
Main Motion (M.M.)

KILL A MOTION,
Postpone Indefinitely (S7)

MODIFY OR CHANGE?
Amend (S6)
Commit or Refer (S5)

LET A FEW STUDY A MATTER?
Commit (S5)

DEFER ACTION?
Postpone to Definite Time (S4)
Make a Special Order
Table (S1)
Reconsider and Enter in the Minutes (U2)

FIX A TIME TO ATTEND TO A MATTER?
Postpone to Definite time (S4)
Make a General or Special Order

STOP OR LIMIT DEBATE?
Previous Question (S2)
Modify Debate (S3)

SUPPRESS THE QUESTION?
Object to Consideration (I8)
Postpone Indefinitely (S7)
Table (Suppresses Temporarily) (S1)

OBJECT TO A DECISION OF THE CHAIR?
Appeal (I1)

DO SOMETHING CONTRARY TO RULES?
Suspend the Rules (I3)

DO SOMETHING CONTRARY TO BY-LAWS?
Change the By-Laws (M.M.)

CORRECT PROCEDURE?
Rise to a Point of Order (I4)

MAKE A REQUEST?
Rise to a Question of Privilege (P4)
Rise to a Parliamentary Inquiry (I5)
Rise to a Point of Information (I5)

DETERMINE THE CORRECTNESS OF AN ANNOUNCED VOTE?
Call for a Division of the Assembly (I7)

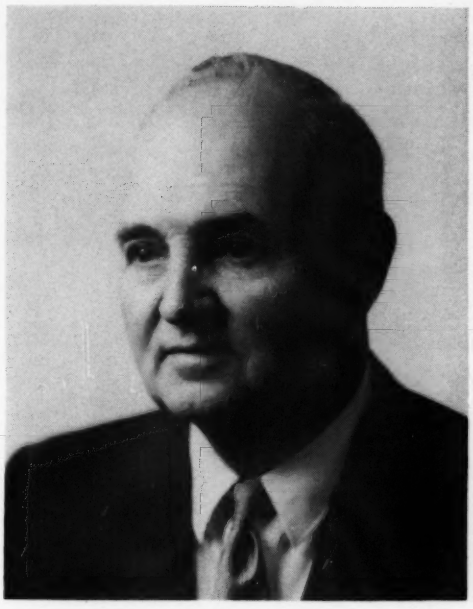
CONSIDER A QUESTION A SECOND TIME?
Take from the Table (U1)
Reconsider (U2)
Rescind (U3)

BRING THE QUESTION AGAIN BEFORE THE ASSEMBLY?
Take from the Table (U1)
Take up a Postponed Question before its proper time
Discharge a Committee
Reconsider (U2)
Reconsider and Enter on the Minutes (U2)
Rescind (U3)
Renew

REPEAL AN ACTION?
Reconsider (U2)
Rescind (U3)

PREVENT FINAL ACTION IN AN UNREPRESENTATIVE MEETING?
Reconsider and Enter on the Minutes (U2)

Contributors Column



Leonard S. Hole

Mr. Hole, author of "The Living Trust for Doctors," is Vice President and Trust Officer of The Farmers Bank of the State of Delaware. He came to the bank from Boston in 1953 after many years of experience in the trust and investment counsel fields. He is a graduate of Western Reserve University and has been a member of the Ohio bar since 1919.

Mr. Hole served in the first World War as First Lieutenant of Field Artillery. After practicing law for three years he entered the Trust Department of the National City Bank of Cleveland, Ohio and later headed the Trust Department of the George D. Harter Bank of Canton, Ohio for eleven years. Prior to his coming to Wilmington he was associated with an Investment Counsel firm in Boston.

Dr. Sheldon Weiss, formerly Child Guidance Psychologist with the N. Y. State Dep't of Mental Hygiene, spent seven years as Director of Psychology Services at the State Hospital for the Criminally Insane, Waymart, Pa. Dr. Weiss is a Member of the American Psychological Association, the Society for Projective Techniques, the American Academy of Psychotherapists and Phi Delta Kappa, a national education research society.

Caleb H. Smith, M.D. is a Diplomate of the American Board of Surgery and American Board of Proctology; a Fellow of the American College of Surgeons and American Proctologic Society. He has published more than thirty scientific papers. Formerly Assistant Professor of Surgery at the University of Rochester, he is currently Lecturer in Proctology at Temple University.

Born in St. John's, New Foundland, Canada, Dr. Patrick F. Ashley received an MDCM at Dalhousie University, Halifax, Nova Scotia, and interned at St. John's General Hospital. After four years in general practice, he came to Wilmington as a resident in pathology at the Memorial Hospital and the Delaware Hospital. He is a graduate Fellow in pathology of the Memorial Hospital, 1958.

John S. Piendak, who recently entered the U.S. Air Force this past August, obtained his medical degree at St. Louis University and interned at the Delaware Hospital, Wilmington. Dr. Piendak is presently stationed at Mitchell Air Force Base, Hempstead, Long Island, New York.

Dr. John W. Alden, Jr., Jefferson Medical College, 42, is a native of Alabama. He completed his residency training at the Delaware Hospital, Wilmington and at the University of Pennsylvania Graduate School of Medicine. His service in the U.S. Army from 1943-1946 saw him in the European Theatre—109 Evacuation Hospital. Dr. Alden is at present Attending Chief in Radiology at the Delaware Hospital, Wilmington.

Dr. Andrew M. Gehret—Jefferson Medical College, Philadelphia, Pennsylvania—is an obstetrician and gynecologist on the active staff of the Delaware Hospital, Wilmington. He served as secretary of the Medical Society of Delaware for several years and is a member of the Delaware State Board of Medical Examiners.

Dr. Aydin Z. Bill, a graduate of Istanbul University, 1958 came to this country to take a post at the Delaware State Hospital as Resident in Psychiatry. He is a Member of the Society of Group Psychotherapy and Psychodrama and has recently had an article published in their Journal on Group Psychotherapy and Psychodrama in Turkey.

MAJOR MEDICAL MEETINGS IN DELAWARE

Standing Schedule

Beebe Hospital	General Staff	2nd Friday	Monthly
Delaware Hospital	General Staff	2nd Tuesday	Feb., May, Sept., Dec.
Kent General Hospital	General Staff	3rd Tuesday	Monthly
Memorial Hospital (Wilmington)	General Staff	2nd Tuesday	Jan., March, June, Oct.
Milford Memorial Hospital	General Staff	2nd and last Tuesdays	Monthly
Nanticoke Memorial Hospital	General Staff	1st Thursday	Monthly
St. Francis Hospital	General Staff	4th Tuesday 1st Tuesday	March, May, Oct. December
Wilmington General Hospital	General Staff	4th Tuesday	Jan., April, Sept., Nov.

Kent County Medical Society	Monthly Meeting	3rd Tuesday	September - June
New Castle County Medical Society	Monthly Meeting	3rd Tuesday	September - June
Sussex County Medical Society	Monthly Meeting	2nd Thursday	September - June

Delaware Academy of General Practice	Monthly Meeting	1st Tuesday	September - June
Delaware Pathology Society	Weekly Meeting	Each Friday	

Special Schedule

Delaware Academy of Medicine	Symposium on Steroids	Academy of Medicine	November 7, 1959
Delaware Academy of General Practice	Annual Meeting	Academy of Medicine	December 5, 1959

LECTURE COURSE

Subject: Basic Electrocardiography

Schedule: Part I

Time — Every Thursday afternoon 4-5 p.m.
Dates: From October 29, 1959 through February 25, 1960

Place: Memorial Hospital, Wilmington

Schedule: Part II

Time — Same as for Part I
Dates: March 3rd through March 31st, 1960
Arrangements must be made for Part II only.

For full details regarding this series write to the Director of Medical Education, Memorial Hospital, Wilmington

TWO-WAY RADIO CONFERENCES FOR THE COMING MONTH

Sponsorship: *Medical Society of Delaware, Pennsylvania Hospital, Smith Kline & French Laboratories.*

Date *Topic and Faculty*

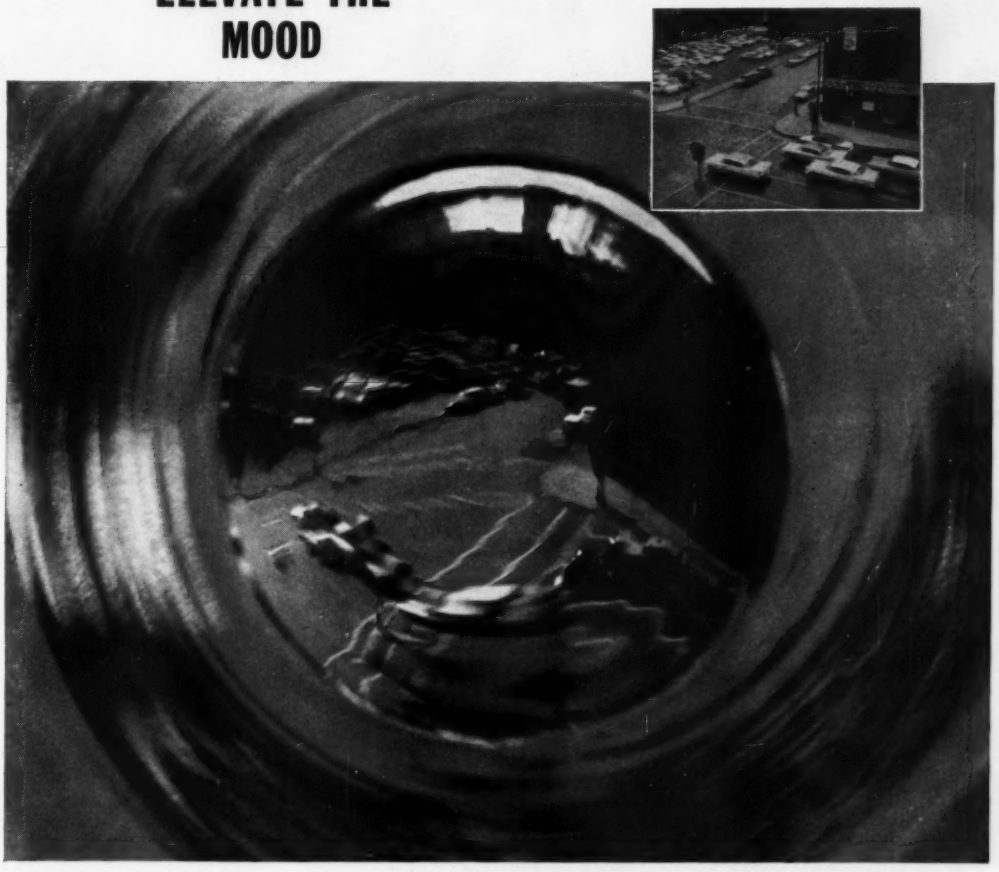
Oct. 27 —"The Role of Diuretics in Cardiovascular Disease," Joseph A. Wagner, M.D., Associate Cardiologist, Pennsylvania Hospital.

Nov. 3 —"Steroid Therapy of Hypersensitivities," George R. Fisher, III, M.D., Assistant Physician, Pennsylvania Hospital.

Nov. 10 —"Diagnosis and Treatment of Vaginitis, Vulvitis, Pruritis," Clarence C. Briscoe, M.D., Assoc. Obstetrician and Gynecologist to Pennsylvania Hospital.

Nov. 17 —"Recognition, Etiology and Treatment of Fetal Distress During Labor," Paul E. Stroup, M.D., Assistant Obstetrician and Gynecologist, Pennsylvania Hospital.

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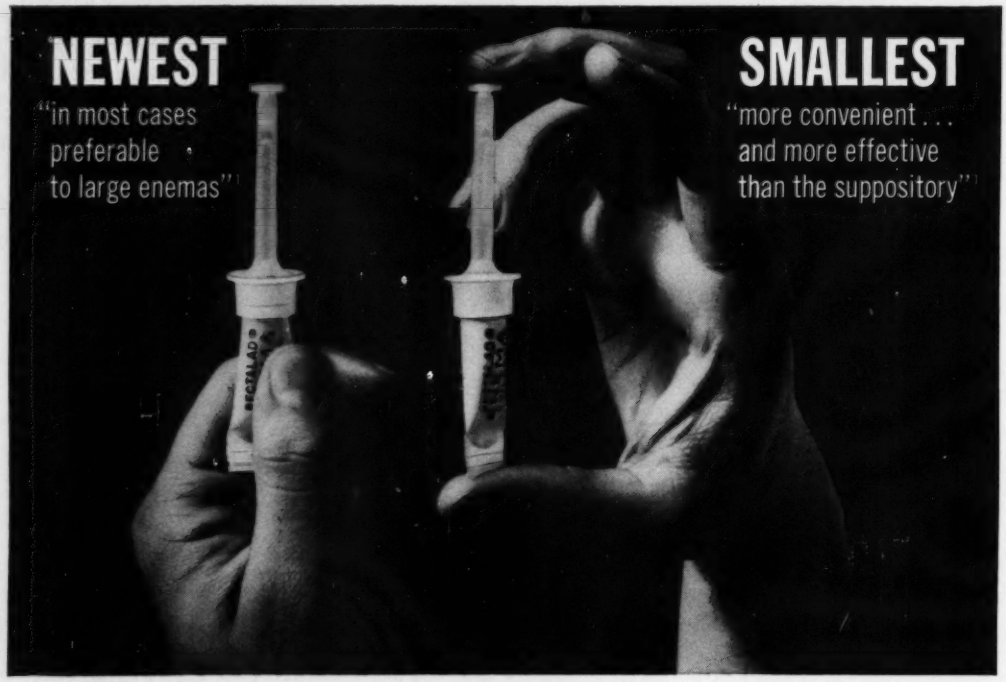
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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet 2:347 (Aug. 16) 1958.

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References: 1. Aries, P. L.: J.A.M.A. *169*:708 (Feb. 14) 1959. 2. Personal Communication on file at Medical Department, Wampole Laboratories. 3. Reports of clinical trials by 9 physicians.

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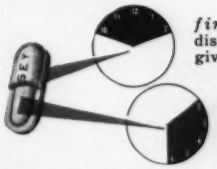
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References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

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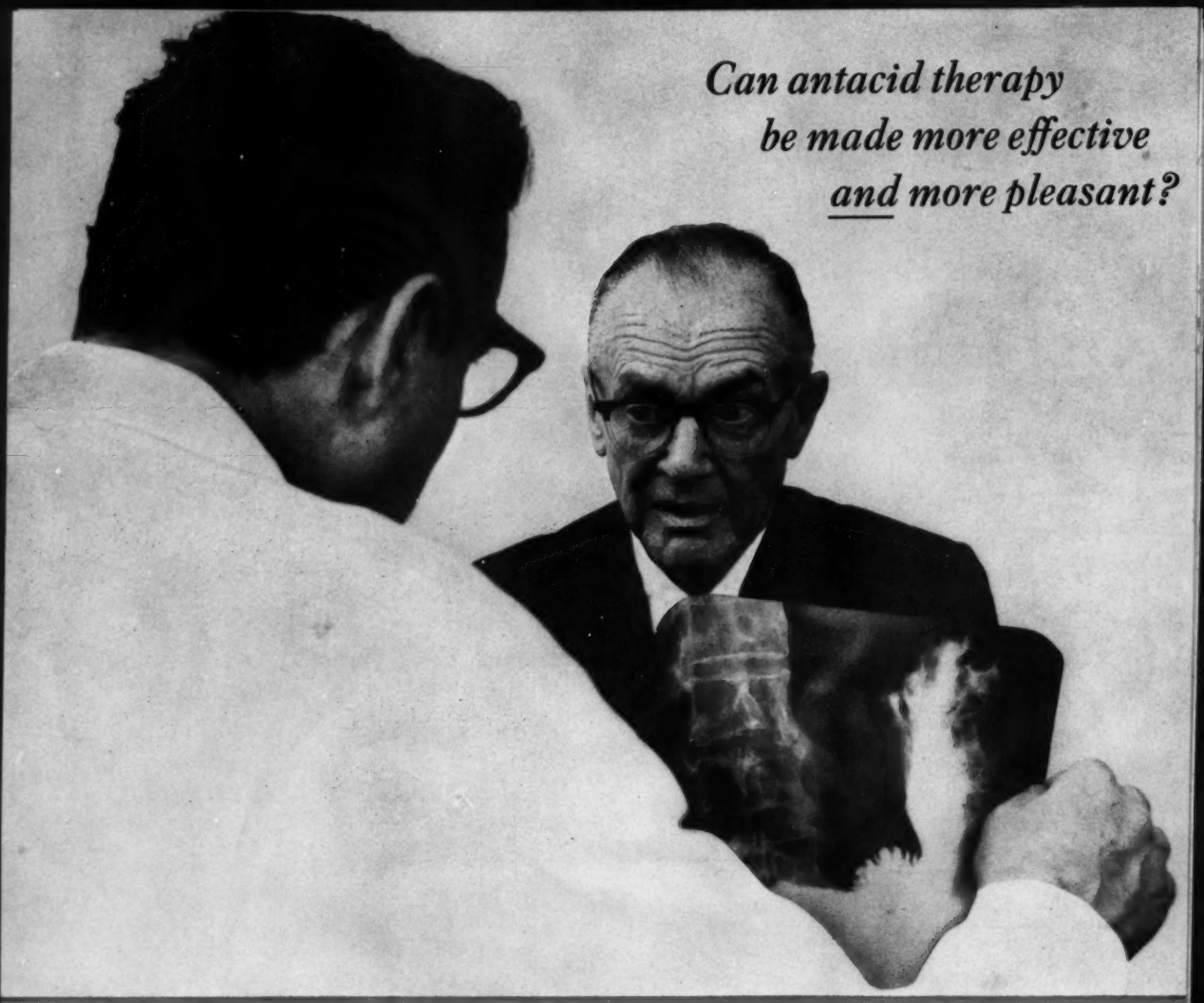
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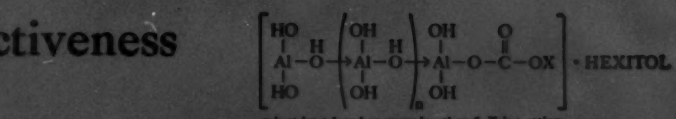
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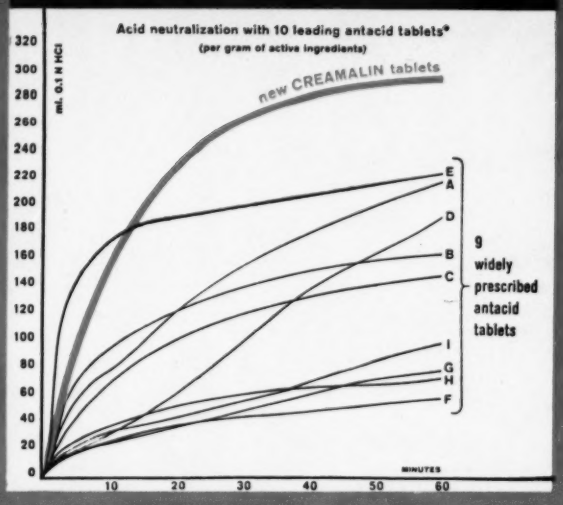
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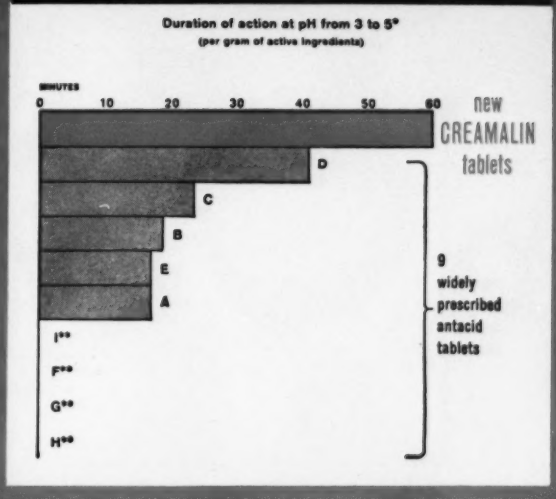
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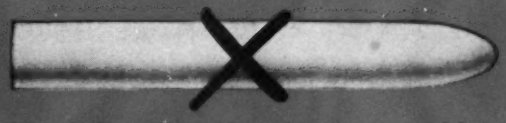
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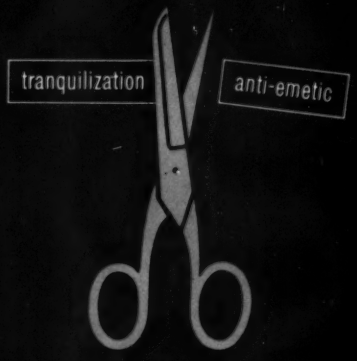
535 N. Dearborn Street

Chicago 10, Illinois

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now potent tranquilizer therapy is safer than ever



Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action – divorced from such "diffuse" effects as anti-emetic action.

MELLARIL is virtually free of such toxic effects as

- jaundice
- Parkinsonism
- blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."

SANDOZ

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has been almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, dermatitis– **even when given in quantities far in excess of the usual dosage.**

"POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."[2]

NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."[3]

SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in any of its forms. Dizziness and sleepiness responded to a reduction in dosage. Other side effects did not occur.... It is singularly free from the side effects ordinarily seen with these [phenothiazine] compounds."[4]

ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common after administration of the phenothiazines, was present during the period of Thioridazine administration: Parkinsonism or Parkinson-like symptoms, photosensitivity, orthostatic hypotension, bone-marrow depression."[1]

MINIMAL SIDE EFFECTS

"Side effects such as extrapyramidal activity, jaundice and photosensitivity have not been observed in patients treated with Thioridazine [Mellaril]. Extrapyramidal side effects produced by other phenothiazines have disappeared promptly with no deterioration in the behavioral response when these patients have been shifted to Thioridazine."[5]

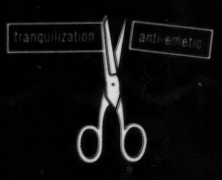
NO JAUNDICE

"No allergic reactions were observed such as skin eruptions, jaundice or agranulocytosis. Central nervous system toxicity, as manifested by extrapyramidal effects, seizures, and excitement did not occur despite the use of high doses (up to 2000 mg.) of the drug."[6]

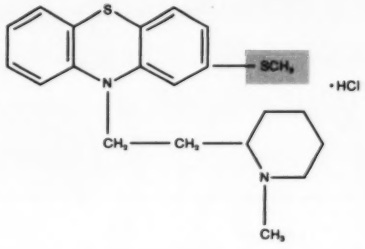
Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

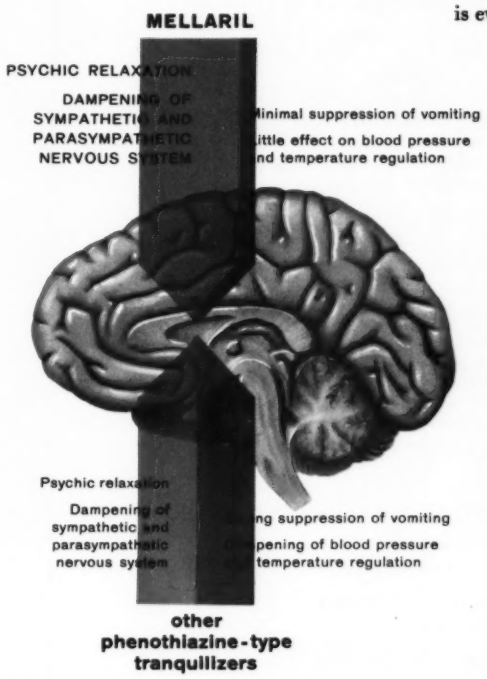


a new advance in tranquilization:
greater specificity of tranquilizing action plus fewer side effects



Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical ($S\text{-}CH_3$) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.





2 Less "spill-over" action to other brain areas – hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.

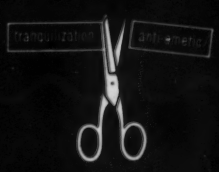
5 Virtual freedom from toxic effects – jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



excellent clinical response

In office practice and in hospitalized patients, Mellaril has proved highly useful for a wide variety of major and minor emotional disorders (such as anxiety, tension, apprehension, alcoholism, agitated psychoneurosis, agitated psychotic states, etc.).

EXTREMELY SATISFACTORY "... produced extremely satisfactory results in the broad therapeutic range represented in this series."[3]

POTENT AGENT "... appears to be a potent agent in the symptomatic management of a variety of psychiatric states."[4]

MAJOR ADDITION TO THERAPEUTICS "This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

AN ACTIVE AGENT "Thioridazine is an active therapeutic agent. . . . It is effective in a variety of psychiatric disorders, including schizophrenic reactions. . . . The drug is particularly advantageous for a group of schizophrenic patients who are sometimes made worse by other phenothiazine derivatives or Rauwolfia alkaloids. It should also be suitable for treating patients with psychoneuroses and chronic brain syndrome."[6]

EVEN IN VERY SEVERE CASES "Of the 152 patients treated 25 have been released and they have not suffered a relapse. This proportion is significant if we stop to consider that we are dealing only with acute cases which had been considered hopeless and obviously destined to finish their days in an asylum."[7]

EXCELLENT THERAPEUTIC RESPONSE "Patients with emotional tensions resulting from the stress and strain of life . . . were treated with Mellaril at the dosage level of 10 mg. three times daily. In 94 such patients, 83 obtained an excellent therapeutic response."[8]

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



"...extremely satisfactory results..."
in a clinical spectrum ranging from
minor nervous disorders to
severe psychotic disturbances[3]

RESULTS WITH MELLARIL IN 194 PATIENTS[3]

ACUTE PSYCHOTICS	CHRONIC PSYCHOTICS	NEUROTICS
83% satisfactory effect	68% satisfactory effect	57% satisfactory effect
Some cases had complete remission of symptoms. Most were able to return home to useful occupations.	Relief of symptoms in cases permitted easier management and a return to a more or less useful life.	Some cases, complete relief of symptoms. Other cases, partial relief of symptoms.

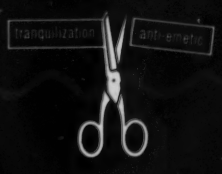
RESULTS WITH MELLARIL IN PATIENTS PREVIOUSLY TREATED WITH OTHER TRANQUILIZERS[3]

DIAGNOSTIC CATEGORY	IMPROVED %	VERY SATISFACTORY %	SATISFACTORY %	UNSATISFACTORY %
SCHIZOPHRENIA				
Acute	89	61	28	11
Chronic paranoid	84.2	31.6	52.6	15.8
Chronic, other	73.9	21.7	52.2	26.1
Residual	57.1	9.5	47.6	42.9
CHRONIC BRAIN SYNDROME	66.6	33.3	33.3	33.3
CHRONIC PSYCHONEUROSIS	62.5	12.5	50	37.5
CHRONIC PSYCHOSOMATIC DISORDERS	75	25	50	25

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered.

Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
	ADULTS	
Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
	CHILDREN	
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hemopoietic depression, jaundice or orthostatic hypotension. As with other phenothiazines, Mellaril is contraindicated in severely depressed or comatose states from any cause.

SUPPLIED: MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lecture, Clinical Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical Association, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, Am. J. Psychiat. *115*:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, American Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. *88*:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (Mellaril) in Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959.

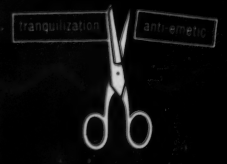
- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc., because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels

SANDOZ

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels



For the first time

CONVENIENCE and ECONOMY

for that all-important first dose of broad-spectrum antibiotic therapy

New

TERRAMYCIN®

brand of oxytetracycline

INTRAMUSCULAR SOLUTION



Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

...and for continued, compatible, coordinated therapy

COSA-TERRAMYCIN®

oxytetracycline with glucosamine

CAPSULES

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

Supply:

*Terramycin Intramuscular Solution**
100 mg./2 cc. ampules
250 mg./2 cc. ampules

Cosa-Terramycin Capsules
125 mg. and 250 mg.

Cosa-Terramycin is also available as:
Cosa-Terramycin Oral Suspension — peach flavored, 125 mg./5 cc., 2 oz. bottle
Cosa-Terramycin Pediatric Drops — peach flavored, 5 mg./drop (100 mg./cc.), 10 cc. bottle with plastic calibrated dropper

Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

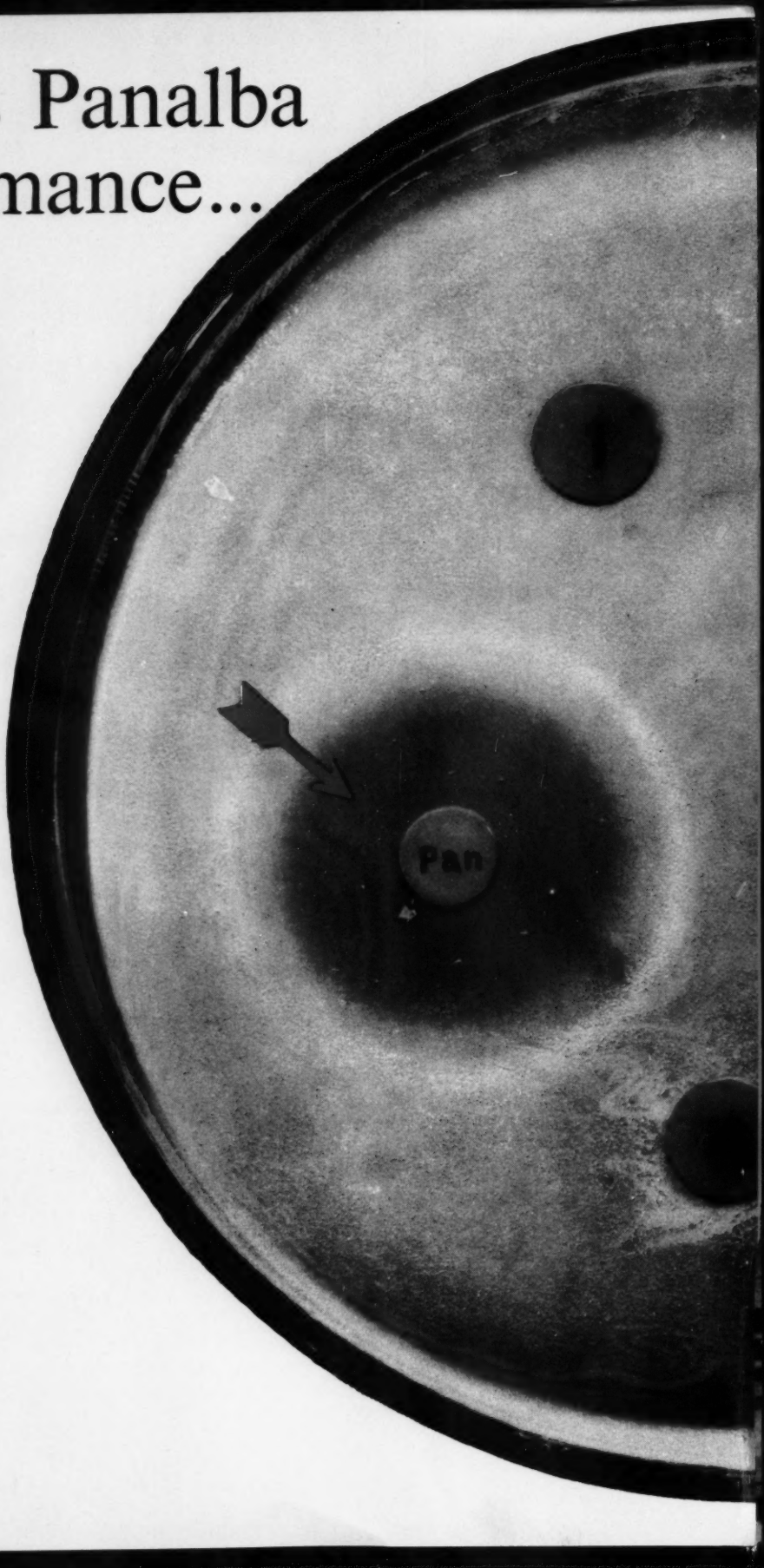
*Contains 2% Xylocaine® (lidocaine), trademark of Astra Pharmaceutical Products, Inc.

Pfizer

Science for the world's well-being™

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

This is Panalba performance...





in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

Panalba*

(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort



Upjohn The Upjohn Company Kalamazoo, Michigan

*TRADEMARK, REG. U. S. PAT. OFF.



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LEDERLE LABORATORIES, a Division of
AMERICAN CYANAMID COMPANY, Pearl River, New York

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Quality Dairy Products
Since 1900

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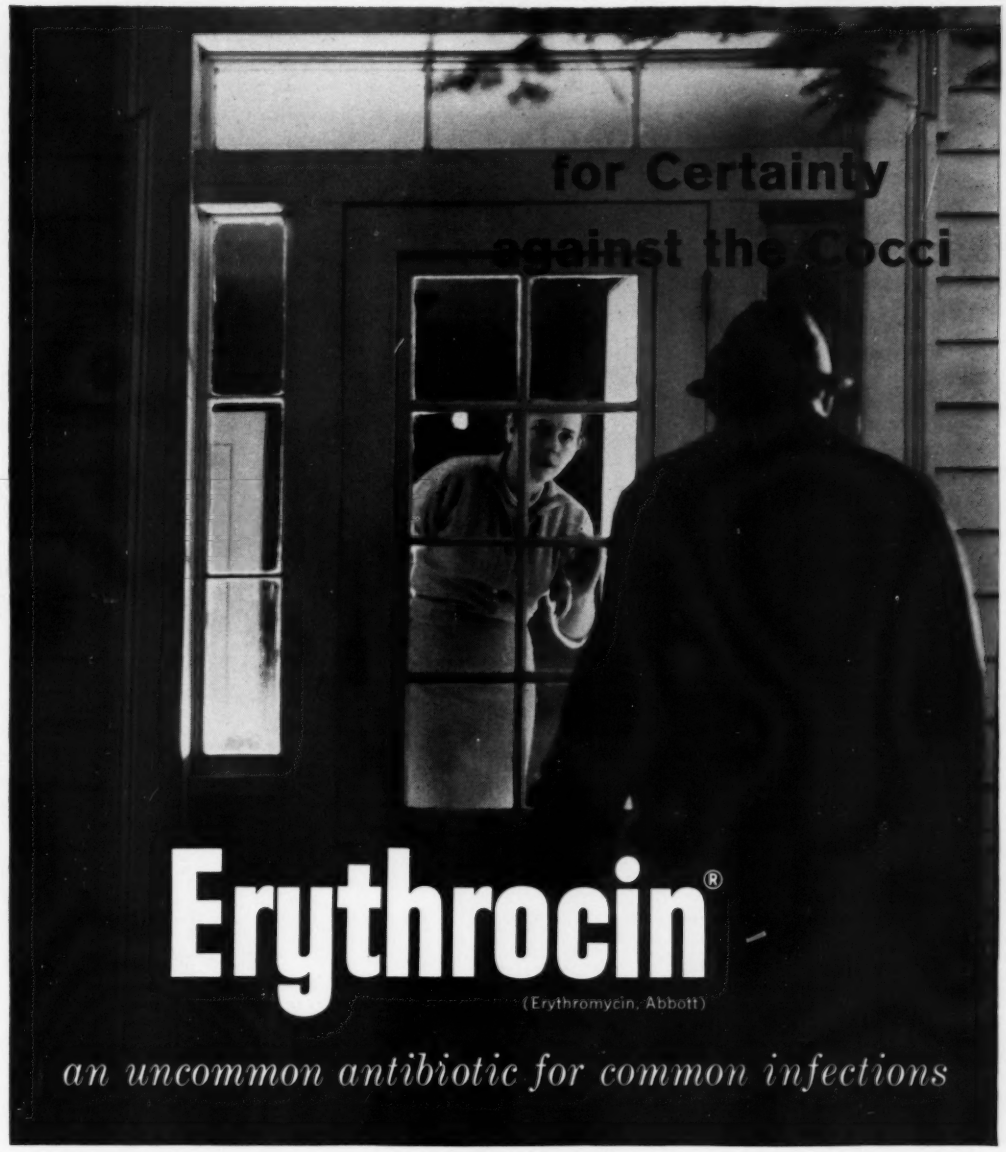
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A. M. E. F.



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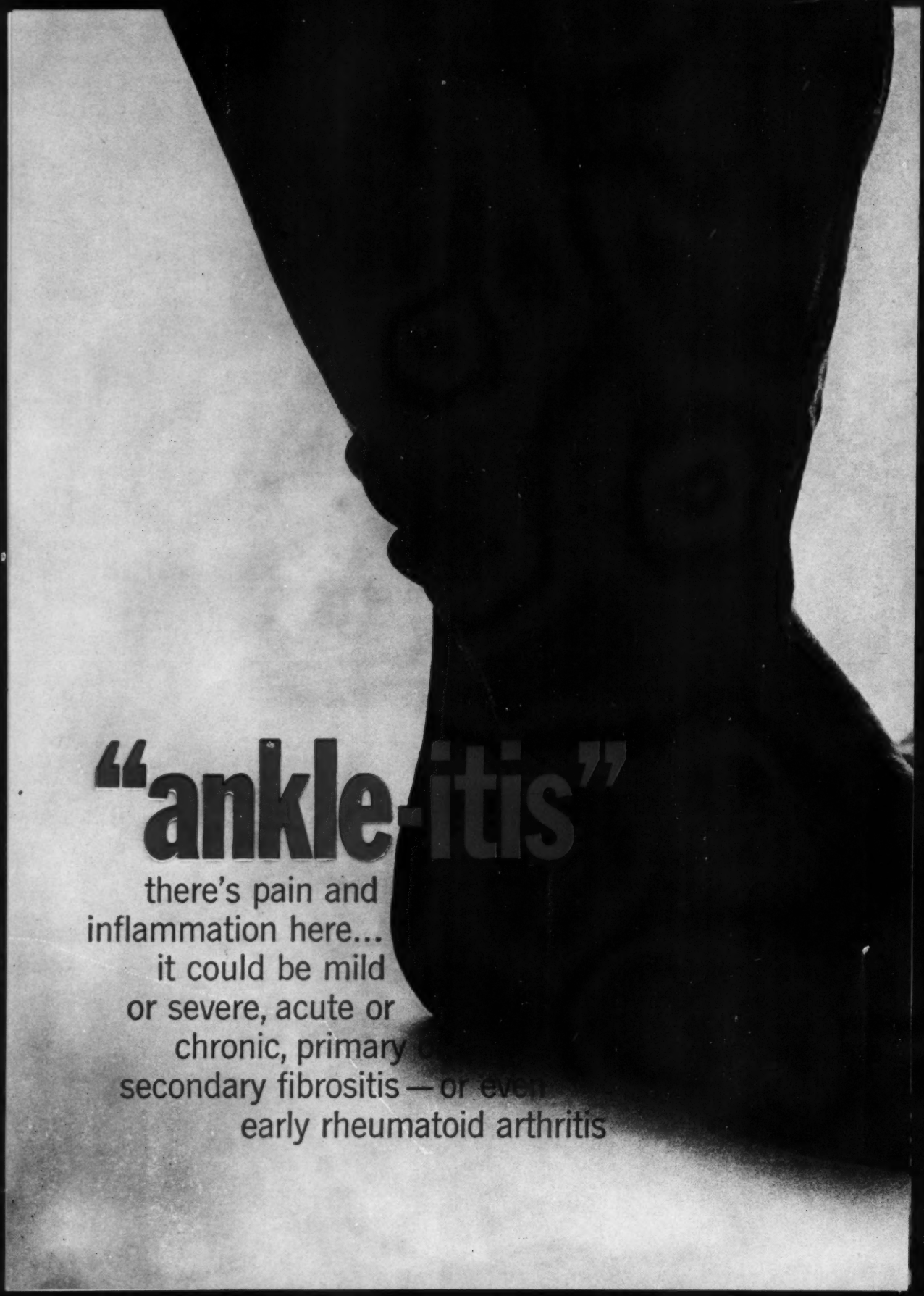


Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs® (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.

ABBOTT

®FILMTABS—FILM-SEALED TABLETS, ABBOTT, U.S. PAT. NO. 2,881,085

909132


"ankle-itis"
there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary
secondary fibrositis — or
early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. . . assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

more conservative and manageable than full-dosage corticosteroid therapy—

. . . much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

THERAPY SHOULD BE INDIVIDUALIZED

acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



in any case it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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natural bowel corrective

Senokot®

STANDARDIZED CONCENTRATE OF TOTAL ACTIVE PRINCIPLES OF CASSIA ACUTIFOLIA PODS PURDUE FREDERICK

TABLETS/GRANULES

REHABILITATES THE CONSTIPATED PATIENT— HELPS RESTORE NORMAL BOWEL TONE, RHYTHM, AND SENSITIVITY.

SUPPLIED: TABLETS: Small and easy to swallow, in bottles of 100.
GRANULES: Cocoa-flavored, in 8 and 4 ounce canisters.

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NEW YORK 14, N.Y. | TORONTO 1, ONTARIO

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More effective than salicylate alone in antirheumatic therapy....

Pabalate®

COMBINING MUTUALLY SYNERGISTIC NON-STEROID ANTIRHEUMATICS

"superior to aspirin" — ". . . evidence seems to indicate that the concurrent administration of para-aminobenzoic and salicylic acid [as in Pabalate] produces a more uniformly sustained level for prolonged analgesia and, therefore, is superior to aspirin in the treatment of chronic rheumatic disorders."[1]

In each enteric-coated PABALATE tablet:

Sodium salicylate (5 gr.)	0.3 Gm.
Sodium para-aminobenzoate (5 gr.)	0.3 Gm.
Ascorbic acid	50.0 mg.





Robins

For the patient who should avoid sodium

Pabalate®-Sodium Free

Same formula as Pabalate, with sodium salts replaced by potassium salts

For the pat who requires ster

Pabalate®-H

Pabalate with Hydrocort

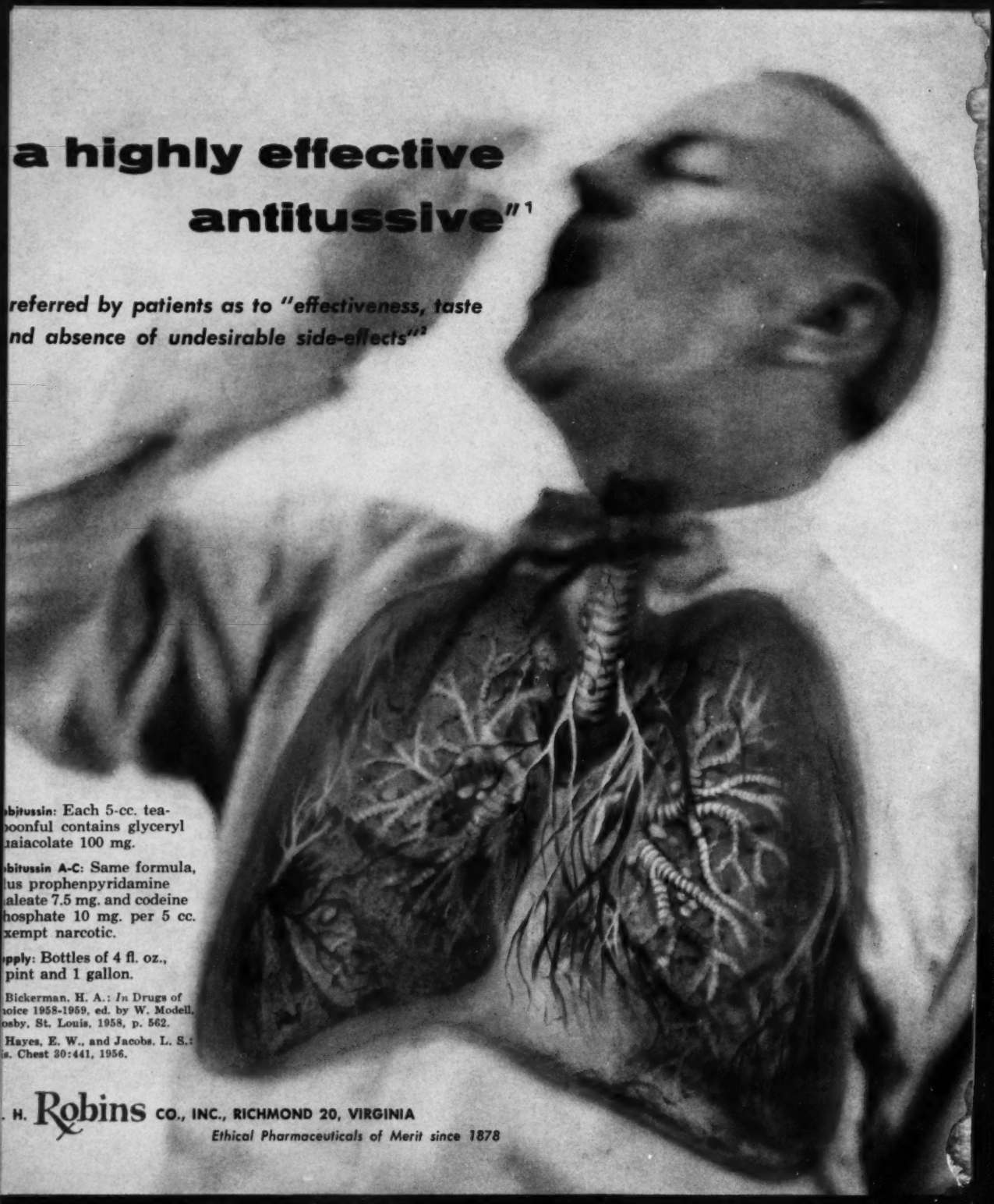
In each enteric-coated PABALATE-HC t

Hydrocortisone	2.
Potassium salicylate (5 gr.)	0.
Potassium para-aminobenzoate (5 gr.)	0.
Ascorbic acid	50.

1. Ford, R. A., and Blanchard Journal-Lancet 78:185,

A. H. ROBINS CO., INC., Richmond 20, Virg

Ethical Pharmaceuticals of Merit since



obitussin: Each 5-cc. tea-
oonful contains glyceryl
uaiacolate 100 mg.

obitussin A-C: Same formula,
lus prophenpyridamine
aleate 7.5 mg. and codeine
hosphate 10 mg. per 5 cc.
xempt narcotic.

pply: Bottles of 4 fl. oz.,
pint and 1 gallon.

Bickerman, H. A.: *In* Drugs of
oice 1958-1959, ed. by W. Modell,
osby, St. Louis, 1958, p. 562.

Hayes, E. W., and Jacobs, L. S.:
s. Chest 30:441, 1956.

H. Robins CO., INC., RICHMOND 20, VIRGINIA
Ethical Pharmaceuticals of Merit since 1878

Robitussin® or Robitussin® A-C

Robins

ROBITUSSIN WITH ANTIHISTAMINE AND CODEINE



it started as a "cold"...

to prevent the sequelae of u.r.i. ... and relieve the symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Pneumonitis, otitis, tonsillitis, adenitis, sinusitis or bronchitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

new hope for fetal salvage

DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein[1] in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that in Delalutin-treated women, fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved. 108 (76%) of 142 babies of this birth weight survived without mothers receiving progestational therapy, while 16 (100%) of 16 babies of this birth weight survived with mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long-acting.

According to Tyler and Olson,[5] "These qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular use than progesterone . . . ."

DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABORTERS



Mary Ann Cribben
Garden City, N. Y.



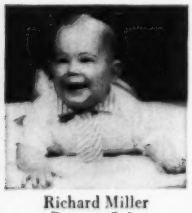
Amy Sue Greenman
Lincolnwood, Ill.



William Peller
Skokie, Ill.



Randy Sinis
Denver, Colo.



Richard Miller
Denver, Colo.



Scott Knudsen
Norwich, Vt.

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

LUTIN

improved progestational therapy

SQUIBB HYDROXYPROGESTERONE CAPROATE

***DELALUTIN** offers these advantages over other progestational agents:*

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum afterpains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and dosage:

Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

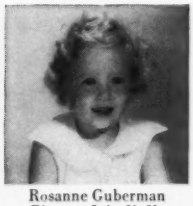
Supply:

Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

Each of these healthy, normal babies was born by a mother with a documented previous history of true habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



Nina Rutkowski
Roselle, Ill.



Rosanne Guberman
Elmont, L.I., N. Y.



Kenneth Michael Simonson
Denver, Colo.



Daniel A. Fabrizio, Jr.
No. Massapequa, L.I., N. Y.



Joanne Verderosa
Seaford, N. Y.



J. Gettemy
Hartford, Conn.

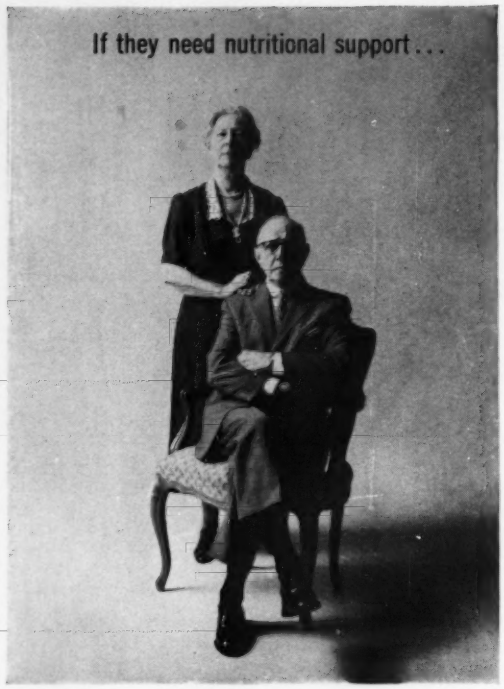


Karen Mary Nederman
East Williston, N. Y.

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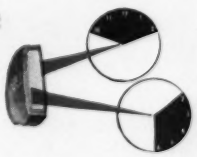
the leading oral nasal decongestant

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- in postnasal drip
- in allergic reactions of the upper respiratory tract.

safer and more effective than topical medication[1,2,3]

- systemic transport to all respiratory membranes
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Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core disintegrates to give 3 to 4 *more* hours of relief

Each TRIAMINIC Tablet provides:
Phenylpropanolamine HCl .....50 mg.
Pheniramine maleate .....25 mg.
Pyrilamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

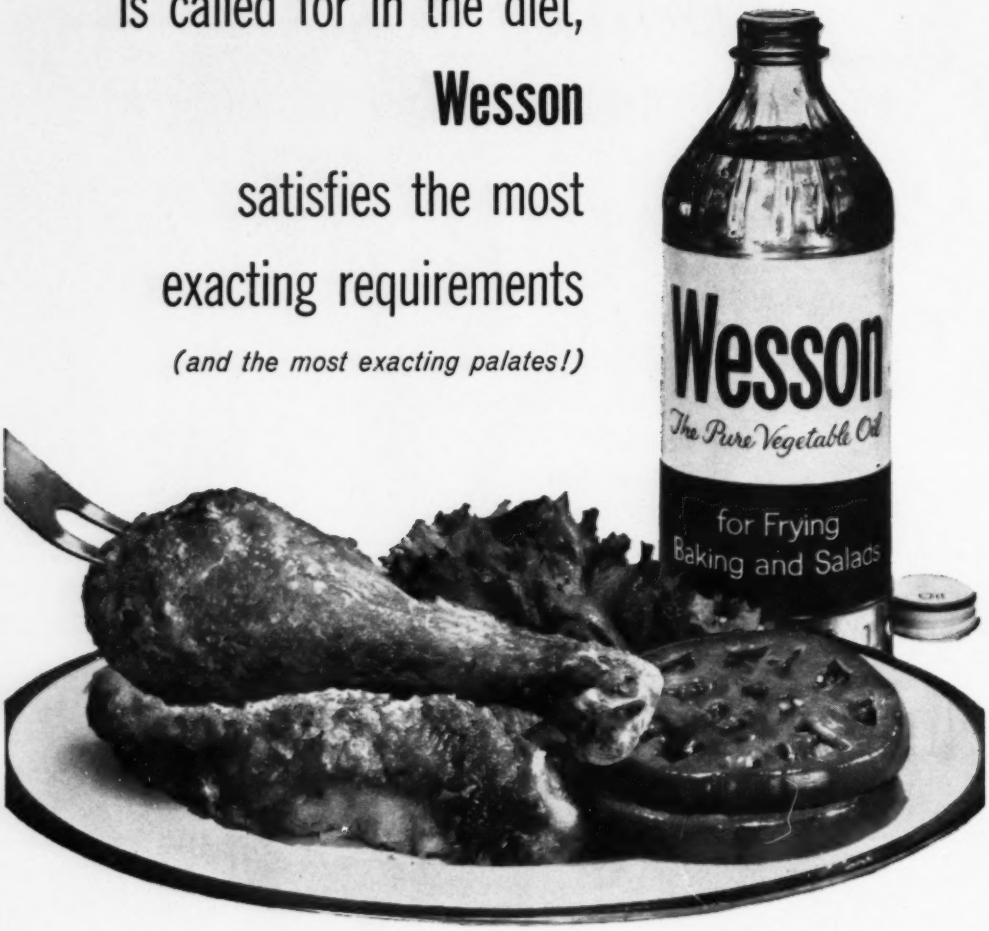
TRIAMINIC JUVELETS: Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to ¼ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

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Phytosterol (predominantly beta sitosterol)	0.4% to 0.7%
Total tocopherols	0.09% to 0.12%
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* Reconfirmed by recent tests against the next leading brand with brand identifications removed, among a national probability sample.



for the tense and nervous patient

relief comes fast and comfortably

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–does not impair mental efficiency, motor control, or normal behavior.

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LOW BACK PAIN

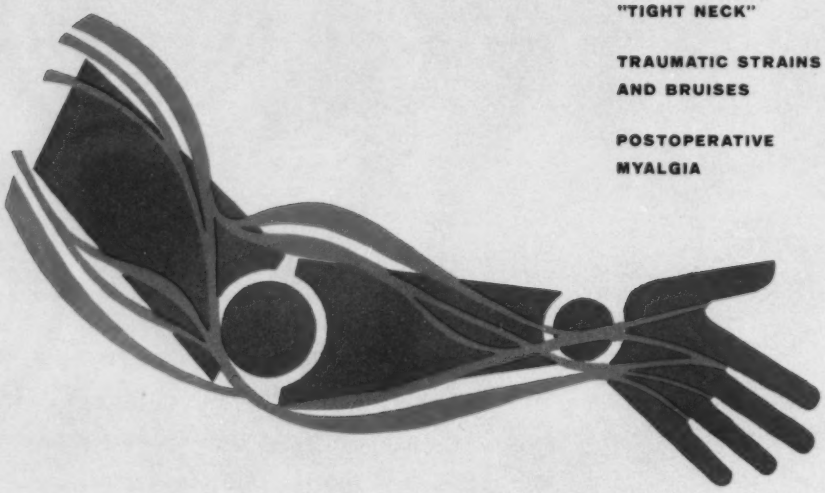
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SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

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NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

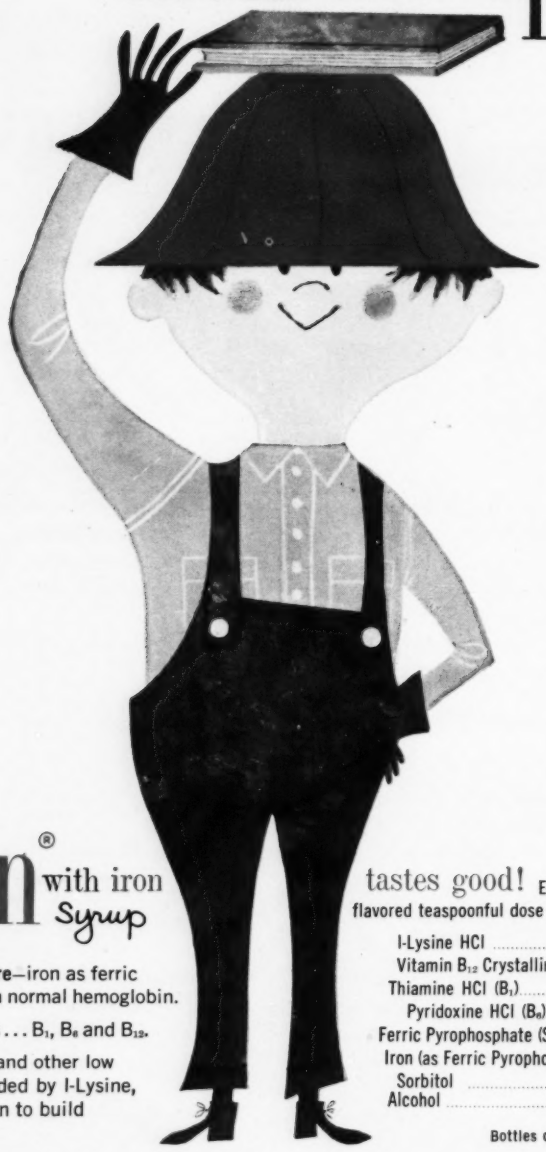
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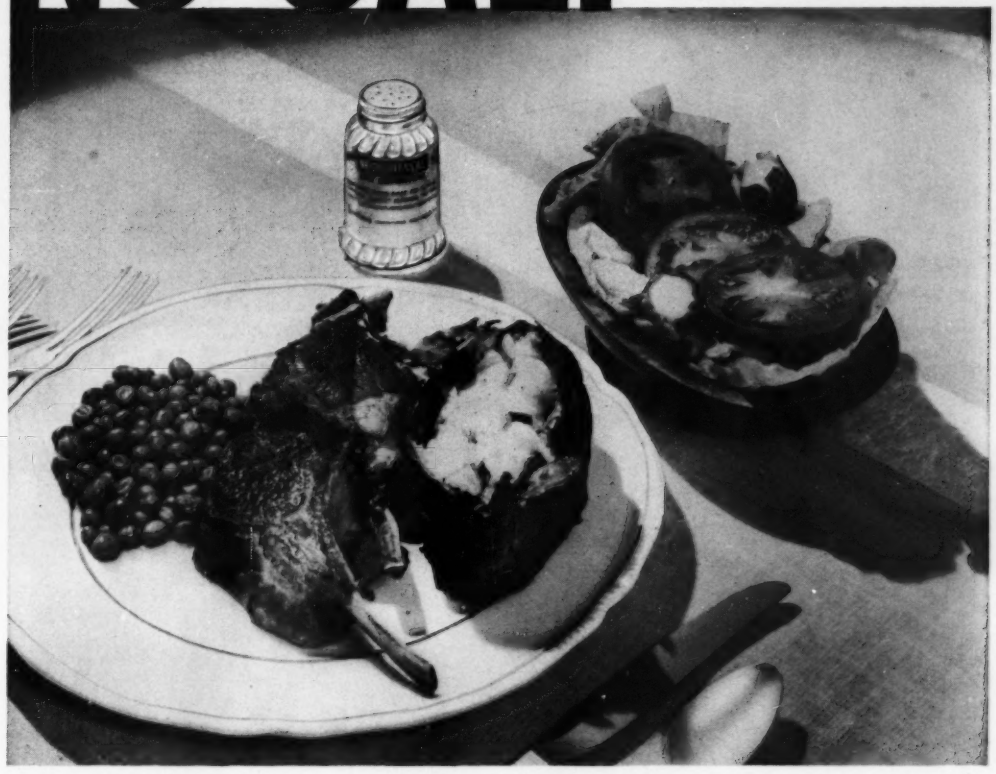
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Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
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Ca Pantothenate	5 mg.
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Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
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Iodine (as KI)	0.1 mg.
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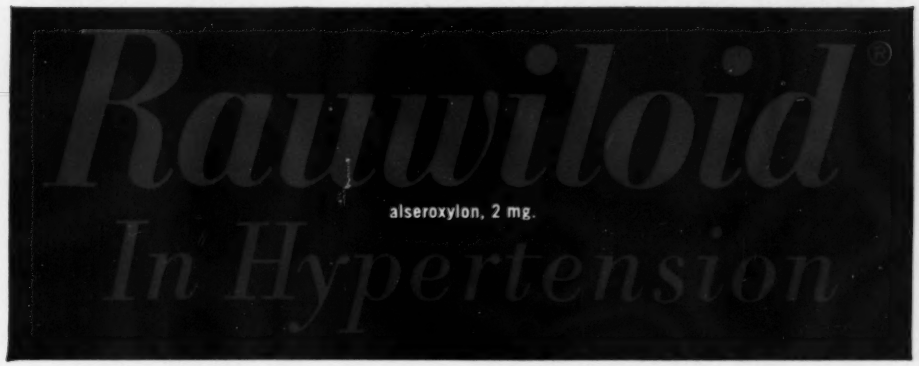
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